# Application for Leave

Pursuant to New York State COVID-19 Leave Law or the Federal Families First Coronavirus Response Act (FFCRA) / Emergency Family & Medical Leave and Emergency Paid Sick Leave

## Section 1 Employee Information

| | |
|---|---|
| Date: | Employee ID #: |
| Employee Name: | Job Title: |
| Department: | CC: |

## Section 2 Leave Request Type

### EMERGENCY FAMILY AND MEDICAL LEAVE:

***Employee must be employed for 30 calendar days to be eligible for Emergency Family and Medical Leave***
*Note: Amount of Emergency Family and Medical Leave days eligible may be reduced based upon use of Family Medical Leave Act (FMLA) days utilized in preceding year.*

☐ Care of a child if the child's school or place of child-care has been closed, or whose childcare provider is unavailable, due to a COVID-19 related reason.

**Child's Name** _____

**School/Facility Name** _____

_____ **(initials) I attest that there is** no other suitable person available to care for my son or daughter

### EMERGENCY PAID SICK LEAVE:

**SELF:**

☐ I AM subject to a federal, State or local quarantine or isolation order related to COVID-19

Governmental Agency issuing order: _____ Date issued: _____

☐ I HAVE been advised by a health care provider to self-quarantine because of COVID-19

Name of health care provider: _____ Date issued: _____

☐ I AM experiencing symptoms of COVID-19 and seeking a medical diagnosis:

Name of health care provider:_____ Date: _____

**FAMILY MEMBER:**

☐ I AM caring for an individual subject to a federal, State or local quarantine or isolation order related to COVID-19 or who has been advised to self-quarantine by a health care provider

Governmental Agency issuing order or name of healthcare provider who advised the individual to self-quarantine

_____ Date issued: _____

Name of individual: _____Relation to employee: _____

## Section 2 *(continued)* Leave Request Type

**FAMILY MEMBER (continued):**

☐ I AM caring for a son or daughter whose school or place of care is closed, or child care provider is unavailable, due to COVID-19 related reasons

**Child's Name** _____ _____

**School/Facility Name** _____

_____ **(initials) I attest that there** no other suitable person available to care for my child.

☐ I AM experiencing substantially similar conditions as specified by the Secretary of Department of Health and Human Services

**NEW YORK STATE COVID-19 LEAVE LAW:**

☐ I AM subject to a federal, State or local quarantine or isolation order related to COVID-19

Governmental Agency issuing order: _____ Date issued: _____

## Section 3 Payroll Election

Please refer to the Nassau County FFCRA Policy for pay caps (maximum daily and aggregated payments) related to EFMLEA or EPSLA leave. Eligible employees will receive the FFCRA leave pay unless a different payroll election is indicated.

**EFMLEA**:

_____ (*initial*) Weeks 1 to 2 ☐ Unpaid Leave ☐ EPSLA ☐ Use of Leave Entitlements

_____ (*initial*) Weeks 3 to 10: ☐ EFLMEA ☐ Use of Leave Entitlements

**EPSLA:**

_____(*initial*) Pay benefits pursuant to the EPSLA; or

_____ (*initial*) Use my leave entitlements instead of EFMLEA or EPSLA.

_____ (*initial*) Use NYS COVID-19 Law (only if subject to a federal, State or local quarantine or isolation order related to COVID-19)

## Section 4 Employee Attestation and Signature

_____ (*initial*) *I am unable to perform my job duties at my work location(s) or remotely.*

Effective Leave Date: _____ Expected Return Date:_____

***I certify that the information provided is truthful and accurate.***

| Print Name | Signature | Date |
|---|---|---|

## Section 5 Review and Approval/Denial

Departmental Human Resources Review for EFMLEA:

Number of FMLA days utilized in preceding year: _____

Department Head Signature: _____ Date: _____ ☐ Approved ☐ Denied

Office of Human Resources Signature: _____ Date: _____ ☐ Approved ☐ Denied

Reason for Denial: _____