# FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA) PAID SICK LEAVE AND EMERGENCY FAMILY AND MEDICAL LEAVE SUBSTANTIATION FORM

**Employee Name:** ____________________________ **Date(s) requested for leave: From:** __________ **To:** __________

**I CERTIFY THAT I AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASON:**

☐ I am subject to a federal, state, or local quarantine or isolation order related to COVID-19. Name of governmental entity ordering quarantine: ____________________

☐ I have been advised by a health care professional to self-quarantine due to COVID-19 concerns. Name of health care professional: ____________________

☐ I am experiencing COVID-19 symptoms and seeking medical diagnosis. Name of health care professional assisting with diagnosis and/or testing recommendations: ____________________

☐ I am caring for an individual subject to a federal, state, or local quarantine or isolation order or advised by a health care provider to self-quarantine due to COVID-19 concerns. Name of person for whom you are providing care: ____________________ Relationship to person for whom you are providing care: ____________________

☐ I am experiencing a substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of Treasury and Secretary of Labor. Please explain: ____________________

☐ I was obtaining a COVID-19 related immunization.

☐ I am recovering from an injury, disability, illness, or condition related to a COVID-19 immunization.

☐ I am seeking or awaiting the results of a diagnostic test or medical diagnosis for COVID-19 and ☐ I have been exposed to COVID-19 or ☐ my employer has requested the test or diagnosis. Name of manager/supervisor requesting test or diagnosis: ____________________

☐ I am caring for my child(ren) because their school or place of care is closed, or their care provider is unavailable due to a public health emergency. Provide the following information for each child:

| Name of Child | Age | School or Place of Care that is Unavailable |
|---|---|---|
| | | |
| | | |

For children older than 14 who require care during daylight hours, provide a statement explaining what special circumstances exist that require you to provide care: ____________________

**Required Check Box for Emergency Family and Medical Leave to care for child:**

☐ I am not able to work or telework due to the need to provide care for the above child(ren) and I attest that no other person will be providing care for the child(ren) during the period for which I am receiving family medical leave.

**I will need:**
*(choose one)*

☐ Continuous leave

☐ Intermittent leave, please describe the nature of your intermittent leave: ____________________

____________________

**I certify that the information provided is accurate and complete. I understand that providing false or misleading information regarding the need for EPSL or any FFCRA qualifying event will be grounds for corrective action, up to and including termination of employment. I understand if I fail to report to work on or before the scheduled return date indicated above or fail to contact my employer regarding my absence from work beyond such scheduled date of return, my employer may take corrective action.**

**Signature:** ____________________ **Date:** ____________________

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