Franklin County
Board of Commissioners
HUMAN RESOURCES
1803

Families First Coronavirus Response Act

Effective April 1, 2020, and applying to COVID-19 related leave needed between April 1, 2020 - December 31, 2020, employees are entitled to limited use, expanded FMLA leave under the Families First Coronavirus Response Act (FFCRA) and/or Emergency Paid Sick Leave under the Emergency Paid Sick Leave Act. Any employee requesting leave provided by this emergency legislation shall complete this form in accordance to the FFCRA. Please return completed form to the Franklin County Board of Commissioners, Department of Human Resources via **fax to 614-525-6573 or email to** BOC-HR-FMLA@franklincountyohio.gov.

To be completed by Employee

Section A – Employee Information

Employee Name: _____
First Middle Last

Employee Contact Info: Work Phone_____Home Phone _____

Work Email_____Home Email _____

Agency Name:_____Employee's job title: _____

Supervisor Name and Contact: _____

Job Status:☐Full Time ☐Part Time Regular work schedule: _____

Employee's essential job functions: _____

_____

Employee is able to telework:☐Yes ☐No*

*If no, explain: _____

_____

_____

Employee has been employed by the Agency for more than 30 days:☐Yes ☐No

Section B – Employee Signature

I hereby certify all statements herein to be complete and true. I certify that I am not able to work, including telework, for the reasons stated in this application. I acknowledge any falsification is cause for discipline up to and including termination of employment.

_____ _____
Employee Signature Date

Section C – Type of Leave Requested

1. Please indicate the type of leave you are requesting (please check all that apply):

☐ Emergency Paid Sick Leave (up to 10 days or 80 hours)

☐ Expanded Family and Medical Leave – COVID-19
(up to 10 weeks or 400 hours after a two week or 80 hour waiting period)

Section D – Emergency Paid Sick Leave

1. Complete if you are unable to work (including telework) because of a COVID-19 qualifying event and are requesting Emergency Paid Sick Leave.

Start date of leave:_____/_____/_____ End date of leave: _____/_____/_____

Indicate frequency of leave (please choose one): ☐ Continuous Leave ☐ Intermittent Leave*

*If your leave will be intermittent, describe the requirements of this use (attach additional information if needed):

_____

_____

_____

_____

2. Check the reason you are unable to work, including unable to telework. You:

☐ 1. are subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

☐ 2. have been advised by a health care provider to self-quarantine related to COVID-19.

☐ 3. are experiencing COVID-19 symptoms and are seeking a medical diagnosis.

☐ 4. are caring for an individual subject to an order described in (1) or self-quarantined as described in (2).

☐ 5. are caring for your child whose school or place of care is closed or unavailable for reasons related to COVID-19.

☐ 6. are experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

Please return completed form to the Franklin County Board of Commissioners, Department of Human Resources via **fax 614.525.6573 or email BOC-HR-FMLA@franklincountyohio.gov**

Section E – Expanded Family and Medical Leave – COVID-19

1. Complete only if you are unable to work (including telework) because of a bona fide need to care for your child (under 18 years of age) whose school or child care provider is closed or unavailable for reasons related to COVID-19.

   Start date of leave:_____/_____/_____ End date of leave: _____/_____/_____

2. Indicate frequency of leave (please choose one): ☐ Continuous Leave ☐ Intermittent Leave*

*If your leave will be intermittent, describe the requirements of this use (attach additional information if needed):

_____

_____

_____

_____

_____

_____

_____

Please indicate number of leave hours needed per workday:

____ Sun_____Mon_____Tues_____Wed_____Thurs_____Fri_____Sat

3. Expanded Family and Medical Leave will consist of unpaid leave for the first ten (10) days or eighty (80) hours of qualified leave. Please indicate if you would request to use accrued leave during this time. ☐ Yes* ☐ No

   *If yes, please specify the type of accrued leave you would like to use:

   ☐ Emergency Sick Leave ☐ Vacation ☐ Comp Time ☐ Administrative Leave

   ☐ Personal ☐ Donated Leave Other (please specify) _____

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To be completed by Human Resources

Employee Name: _____

Employee Agency: _____

FMLA Year Start Date:_____ FMLA Year End Date: _____ FMLA hours used to date:_____

☐ **Emergency Paid Sick Leave**

☐ Not Approved Reason: _____

☐ Approved* Date Span: _____

Number of hours approved:_____

*If approved, applicable conditions of use of leave: _____

_____

_____

☐ **Expanded Family and Medical Leave COVID-19**

☐ Not Approved Reason: _____

☐ Approved* Date Span : _____

Number of hours approved:_____

*If approved, applicable conditions of use of leave: _____

_____

_____

Date Received:_____ Date Completed: _____

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