DAYTON
PUBLIC SCHOOLS

Book	Policy Manual
Section	SECTION G - PERSONNEL
Title	GBR-E
Code	Emergency Family and Medical Leave Expansion Act Request Form
Status	Recommended
Last Reviewed	May 19, 2020

Families First Coronavirus Response Act - Paid Sick Leave/Family Leave Request Form

Employee Name: _____

Telephone Number: _____ Email Address: _____

Address: _____

Date leave is to Begin:_____ Date Leave is to End: _____

Reason for Leave:

- Is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
- Has been advised by a health care provider to self-quarantine related to COVID-19;
- Is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
- Is caring for an individual subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or has been advised by a health care provider to self-quarantine related to COVID-19;
- Is caring for a child whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19; or
- Is experiencing any other substantially-similar condition specified by the Secretary of Health and Human Services

I certify that I am unable to work, including telework, because of the above reason. Yes _____ No _____

If ordered to quarantine or isolate by a governmental entity, the name of the governmental entity ordering such quarantine:
_____

If caring for an individual, the name and relation of the individual: _____

If ordered to quarantine or isolate by a medical professional, the name of medical care professional requiring the quarantine or isolation: _____

If to care for a child whose school or place of care is closed, the name of the child/children: _____; the name of closed school or child care entity: _____. I certify that no other person will be caring for the child during the period for which I am receiving paid leave. Yes _____. If all of the children are over 14 years of age, a special statement explaining the need for care must be submitted.

Doctor's Note/Other Documentation Required to Return to Work? Yes _____ No _____

I certify that the above information is true and correct to the best of my knowledge. I understand that falsification of documentation is a dischargeable offense.

Employee Printed Name: _____ Date: _____

Employee Signature (electronic or per authority, if necessary): _____

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