

# DONOHUE

*Integrity and Vision Since 1884*

## Families First Coronavirus Response Act (FFCRA) - Amended EMERGENCY PAID SICK LEAVE REQUEST FORM

effective July 1, 2021 – September 30, 2021

<b>Employee Name:</b>	<b>Telephone Number:</b>
<b>Home Address:</b>	<b>E-mail:</b>
<b>Employee Division:</b>	<b>Supervisor:</b>
<b>Anticipated Start of Leave:</b>	<b>Expected Return to Work Date:</b>

**Reason (s) for Leave** - I am unable to work (or telework) for the following reasons (*check all that apply*):

1. I am obtaining a COVID-19 Immunization.
2. I am recovering from an injury, disability, illness, or condition related to COVID-19 immunization.

I understand that under reason #1 – to obtain a COVID-19 immunization – I am eligible to receive up to four hours of paid sick leave for each vaccination shot, up to eight hours total. And, a maximum of four hours of paid sick leave for one-shot vaccinations.

**Use of Company Vacation and Sick Leave** - I understand that under the Federal Emergency Sick and Family Medical Leaves, I may only be eligible to receive a percentage of my salary. In the case of reduced salary, I would like to request \_\_\_\_ (#) of vacation hours and \_\_\_\_ (#) of sick hours.

I certify that the above information is accurate and complete and I agree to supply my Human Resources department with documentation to support my request for leave if requested. I understand that I must report to work by my expected return to work date or contact Human Resources if I need to extend leave beyond that date. I must also abide by the Company's COVID-19 policy, including but not limited to notification and return to work guidelines.

**Employee Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**For HR Use Only**

**Approved – Date:** \_\_\_\_\_ **Denied – Reason** \_\_\_\_\_

**Requested Document – Specify:** \_\_\_\_\_

**HR Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_