

IMCB-MWR-

Date:

MEMORANDUM FOR (Supervisor's Name): _____

SUBJECT: Request for Leave Under the Families First Coronavirus Response Act (FFCRA)

1. I'm requesting _____ hours of Emergency Paid Sick Leave (EPSL) covering the period of _____ to _____ (total leave under EPSL cannot exceed a total of 80 hours).

2. Qualifying Factor (Select one)

____ (1) is subject to a federal, state, or local quarantine or isolation order related to COVID-19;

____ (2) has been advised by a health care provider to self-quarantine related to COVID-19;

____ (3) is experiencing COVID-19 symptoms and is seeking a medical diagnosis;

____ (4) is caring for an individual subject to a quarantine or isolation order or self-quarantine;

____ (5) is caring for a child under (18 years of age) whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19;

____ (6) is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor.

3. Supporting Documentation:

____ Employee's name: _____

____ Date(s) for which leave is requested: _____

____ Qualifying reason for leave: _____

____ A written statement from an appropriate authority, as it pertains to the qualifying reason provided (including self-quarantine), that the employee is unable to work or telework because of the COVID-19 qualifying reason for leave.

____ If an employee requests emergency paid sick leave due to quarantine or isolation order, the employee must also provide the name of the government entity that issued the order.

____ If an employee requests emergency paid sick leave because a health care provider advised to self-quarantine, the employee must also provide the name of the health care provider.

____ If the employee requests emergency paid sick leave because they are caring for an individual subject to a quarantine or isolation order or self-quarantine the employee must also provide the name of the government entity that issued the order or name of the health care provider who advised the individual being cared for to self-quarantine.

____ If an employee requests emergency paid sick leave to care for a child whose school place of care is closed, the employee must also provide:

____ The name of the son or daughter being cared for: _____

____ The name of the school, place of care, or child care provider that has closed or become unavailable; _____

____ A written statement from the employee that no other suitable person will be caring for the son or daughter during the period for which the employee takes paid sick leave.

4. ____ I understand that for Factor 1-3, I will be paid at 100% of my pay up to the maximum allowed. For factors 4-6, I will be paid at two-thirds (2/3) of my regular rate of pay up to the maximum allowed.

5. ____ AF: I understand my ATAAPS time card will be coded using LV-Excused Absence and environmental hazard code "DX" for emergency paid sick leave paid at my full rate of pay, and environmental hazard code "DY" for emergency paid sick leave paid at two-thirds of my rate of pay. I further understand that the payroll system is not currently programed to accept these codes and corrected time cards will have to be submitted. I also understand that the payroll system is not programed to make the two-thirds payments and if I am requesting this sick leave for factors 4-6 I will be paid at my full salary and will incur a debt for the remaining one-third at a later date.

6. ____ NAF: I understand that until the NAF (ePay) payroll system is updated to accept the new codes for ESPL, I will be paid at my full rate. Once the payroll system is updated with the new codes for EFMLA, corrected time cards will be submitted to the payroll office which will result in DFAS/NFS executing a collection action on the owed debt.

7. ____ I understand that leave under the FFCRA may result in a debt that will be collected at a later date, and that I will be ineligible to receive a debt waiver for this overpayment.

ENCL

Employee's signature: _____
Employee's typed name: _____

Supervisor's signature; _____
Supervisor's typed name: _____

Approved /Disapproved
(please check either approved/disapproved)

Comments:

Stacye Downing
Director, FMWR