Families First Coronavirus Response Act Form

Emergency Paid Sick Leave Act (EPSL) and/or

Public Health Emergency Leave (PEHL)

To approve your request for leave to be covered under the Temporary Leave Policy Changes pursuant to the Families First Coronavirus Response Act (FFCRA), Atrium Health is requesting information and documentation related to your request. Please complete this form and attach any relevant documentation as necessary. Please contact HR Leave Administration through the HR Service Center with any questions.

Part A: Teammate Information

Teammate Name: _____

Teammate ID: _____

Job Title: _____

Date of request: _____

Part B: Emergency Paid Sick Leave (EPSL) *(to be completed by teammate)*

Reason and Documentation for EPSL (Please mark those that apply and fill in the required information)

1. Subject to a Federal, State, or local quarantine or isolation order related to COVID-19? ☐
    - Please provide the name of the government entity that issued the quarantine or isolation order related to COVID-19.

_____

2. Have been advised by a health care provider to self-quarantine (not by choice) due to COVID-19 symptoms? ☐
    - Please provide the name of the health care provider who advised you to self-quarantine for COVID-19 related reasons.

_____

3. Experiencing COVID-19 symptoms and seeking a medical diagnosis? ☐
4. Is caring for an individual subject to an order described in (1) or self- quarantine as described in (2)? ☐

- Please provide either (1) the name of the government entity that issued the quarantine or isolation order related to COVID-19 **or** (2) the name of the health care provider who advised the individual to self-quarantine for COVID-19 related reasons.

_____

- Please also provide (1) the name of the individual as well as (2) your relationship to the individual.

_____

_____

5. Caring for a child whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19? ☐
    - Please provide (1) the name(s) of the child(ren) being cared for, (2) the name of the school, place of care, or child care provider that closed or became unavailable due to COVID-19 reasons, **and** (3) a statement representing that no other suitable person is available to care for the child during the period of requested leave.

_____

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6. Is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury? ☐

    If you are requesting EPSL for any reason, please provide the following additional information below: (1) state whether, in your assessment, you are able to perform your job, in whole or in part, by teleworking; and (2) if so, please explain why you nevertheless need EPSL even though you are able to telework.

    _____

    _____

    _____

    _____

    Note: EPSL may only be taken in full-day increments. The only exception is if a teammate is teleworking or taking EPSL due to COVID-19 childcare reasons (item 5 above). Please contact HR Leave Administration through the HR Service Center for further information regarding potential leave increments for EPSL.

    Requested Leave Start Date (mm/dd/yyyy): _____

    Requested Leave End Date (mm/dd/yyyy): _____

Additional Comments (please do not provide any confidential medical information):

_____
_____
_____
_____

Approval of EPSL Request *(to be completed by HR Leave Administration)*

Approved: Yes ☐ No ☐ (Reason if not approved:_____)

Approved Leave Start Date (mm/dd/yyyy): _____

Approved Leave End Date (mm/dd/yyyy): _____

Able to Telework (If applicable): Yes ☐ No ☐

Comments:

_____
_____
_____

Signature: _____

Name (Printed):_____ Date: _____

Part C: Public Health Emergency Leave (PHEL) *(to be completed by teammate)*

Teammate Name: _____

Name(s) of child(ren) being cared for: _____

Name of school, place of care, or childcare provider: _____

Requested Leave Start Date (mm/dd/yyyy): _____

Requested Leave End Date (mm/dd/yyyy): _____

Please provide the following additional information below: (1) state whether, in your assessment, you are able to perform your job, in whole or in part, by teleworking; and (2) if so,

please explain why you nevertheless need PHEL even though you are able to telework and your proposed schedule for use of PHEL. Please also provide (3) a statement representing that no other suitable person is available to care for the child during the period of requested leave.

_____

_____

_____

_____

Note: Please contact HR Leave Administration through the HR Service Center for further information regarding leave increments.

Additional Comments (please do not provide any confidential medical information):

_____

_____

_____

_____

Approval of PHEL Request *(to be completed by HR Leave Administration)*

Approved: Yes ☐ No ☐ (Reason if not approved:_____)

Approved Leave Start Date (mm/dd/yyyy): _____

Approved Leave End Date (mm/dd/yyyy): _____

Able to Telework (If applicable): Yes ☐ No ☐

Employed for at least 30 days: Yes ☐ No ☐

Signature:_____ Date: _____

Name (Printed): _____

Part D: Teammate Certification

I certify that the information I provided on this form is accurate and complete and that I am unable to work or telework because of the COVID-19 qualifying reason selected above.

Teammate Signature: _____

Date: _____

Fax completed form to 704-446-6624