



City of Commerce

Families First Coronavirus Response Act Emergency Federal Paid Sick Leave and Emergency FMLA Leave

Employee Name: _____ Date of Request: _____
Department: _____ Position: _____
Personal Email: _____ Phone Number: _____

Emergency Paid Sick Leave Request

I hereby request Emergency Paid Sick Leave for the following reason (check one):

1. Employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19. *(Employee is required to submit documentation as requested by Human Resources.)*
2. Employee has been advised by a health care provider to self-quarantine related to COVID-19. *(Employee is required to submit documentation as requested by Human Resources.)*
3. Employee is experiencing COVID-19 symptoms and is seeking a medical diagnosis. *(Employee is required to submit documentation as requested by Human Resources.)*
4. Employee's is caring for an individual who has been subject to a Federal, State or local quarantine or isolation related to COVID-19 or caring for an individual who has been advised to self quarantine related to COVID-19.
5. Employee is caring for a child or other individual who is unable to care for themselves due to the COVID-19 related closing of their school, child care facility, or other care. *(Employee must submit copy of government, school or day care website published in a newspaper or an email from an employee or official in the school, place of care or child care provider.)*
6. The employee is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

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Emergency FMLA Request

I hereby request Emergency FMLA Leave for the following reason:

1. Employee is caring for a minor child due to closure of the minor's school or place of child care due to COVID-19. *(Employee must submit copy of government, school or day care website published in a newspaper or an email from an employee or official in the school, place of care or child care provider.)*

First day of leave: _____

Last day of leave: _____

Expected Return to Work Date: _____

I understand that I am prohibited from entering a City facility until I am cleared to return by Human Resources.

During the duration of my leave, I am required to maintain communication with Human Resources and my supervisor regarding updates to my leave status.

If the duration of my Emergency Paid Sick Leave does not exceed the typical number of hours I work in a typical 2 week period, I will be returned to my same or equivalent position. If the duration of my Emergency FMLA Leave does not exceed 12 weeks, I will be returned to my same or equivalent position. I understand that Emergency Paid Sick Leave and Emergency FMLA Leave run concurrently and that all leave taken for any FMLA-qualifying reason will count towards my 12 work weeks within a 12 month period. I understand that should my approved leave exceed the approved period of time my employment may be terminated by the City.

Date

Employee Signature