City of Northampton
REQUEST FOR LEAVE UNDER THE
FAMILES FIRST CORONA RESPONSE ACT
April 1, 2020 – December 31, 2020

Employee Name:_____ Date of Request:_____

Department:_____ Position:_____

I am requesting a leave for a qualifying reason related to COVID-19. I am unable to work, or telework because I:

1. am subject to a Federal, State or Local quarantine or isolation order related to COVID-19;
2. have been advised by a health care provider to self-quarantine related to COVID-19;
3. am experiencing COVID-19 symptoms and am seeking a medical diagnosis;
4. am caring for a qualified individual subject to an order described in (1) or self-quarantine as described in (2);
5. am caring for my child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons;
6. am experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

I am requesting that my leave begin on:_____ and continue for _____.
Date Period of time

I am requesting a continuous leave _____ , OR intermittent leave _____, # of hours per day/week _____
I understand that I must provide documentation to verify my need for leave:

☐ 1, 2 & 4) the name of the governmental entity ordering quarantine or the name of the health care professional advising self-quarantine:_____

☐ 4 & 5 Name and relationship of qualified individual or name and age of child/children, name of school or place of care that is closed and documentation of the closure related to COVID-19_____

_____

I certify that all information that I have provided is true and accurate to the best of my ability. I further assert that if I am taking leave for reason #5 that no other person will be providing care for the child during the period for which I am receiving family medical leave and, with respect to my inability to work or telework because of a need to provide care for a child older than fourteen during daylight hours then I will provide a statement that special circumstances exist requiring me to provide care. I understand that my group health insurance will continue for the duration of any qualified FMLA eligible leave and that I must continue to pay my regular contribution.

_____
Employee Signature Date

DEPARTMENT HEAD:

_____
Department Head Date

HUMAN RESOURCES:
Designation of Leave Request:

☐ FMLA ☐ Non-FMLA

_____
Signature Human Resource Specialist Date
Comments/other info:
Revised 3/30/2020