EMPLOYEE RIGHTS

PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

The **Families First Coronavirus Response Act (FFCRA or Act)** requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

▸ PAID LEAVE ENTITLEMENTS

Generally, employers covered under the Act must provide employees:

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- ⅔ for qualifying reasons #4 and 6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at ⅔ for qualifying reason #5 below for up to $200 daily and $12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

▸ ELIGIBLE EMPLOYEES

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). *Employees who have been employed for at least 30 days* prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

▸ QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19

An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to **telework**, because the employee:

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 an order described in (1) or self-quarantine as described in (2);
5. is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
6. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

▸ ENFORCEMENT

The U.S. Department of Labor's Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

For additional information or to file a complaint:
1-866-487-9243
TTY: 1-877-889-5627
dol.gov/agencies/whd

WH1422 REV 03/20

COVID-19 Paid Leave Request Form

Employee Name:	**Date of Application:**
Position & Building:	**Dates of Requested Leave:**

I, _____, an employee of Thousand Island Central School District, affirm that I am hereby unable to work or telework due to the COVID-19 reason below (check all that apply), and that the information provided and attached to this form is accurate:

1. ☐ **I am subject to a federal, state, or local quarantine or isolation order related to COVID-19**[1]

   **Include the name and address of the government entity that issued the quarantine or isolation order to which the employee is subject*: _____

   _____.

2. ☐ **I have been advised by a health care provider to self-quarantine due to COVID-19**

   **Include the name and address of the health care provider who advised you to self-quarantine*:__

   _____

   _____.

3. ☐ **I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.**

   **Include the name and address of the health care provider who you will be seeking a diagnosis from:* _____

   _____.

4. ☐ **I am caring for an individual who is subject to a federal, state, or local quarantine or isolation order related to COVID-19 or whose health care provider has advised the individual to self-quarantine:**

   **Include either: (1) The name and address of the government entity that issued the quarantine or isolation order:* _____

   _____, ***OR***

   *(2) The name and address of the health care provider who advised the individual to self-quarantine:*_____

   _____

   _____.

1 Please note that if an employee has been quarantined/isolated by a State or Local Health Department order, he/she will be eligible for the New York State Quarantine Leave Law that provides employees with at least 14 days of paid leave (at the employee's full regular rate) for that quarantine/isolation period (unless the employee is able to telework). This leave can be used before or after the Federal Families First Coronavirus Response Act (FFCRA) leave described in question 1.

5. ☐ **I am caring for my child due to my child's school or place of care being closed or my child's care provider is unavailable due to COVID-19**

**Include the following information:*

- *Name and age of the child(ren) being cared for:* _____

  _____

- *Name and address of the school, place of care, or child care provider that closed or became unavailable due to COVID-19 reasons:* _____

  _____

  _____

- *By initialing here* _____, *I certify that no other suitable person is available to care for the child(ren) during the period of requested leave. If I have listed any child(ren) over the age of 14, I certify that special circumstances exist that require me to provide care for said child(ren). Those special circumstances are as follows:*

  _____

  _____

  _____

  _____

  _____

- *I will need this leave intermittently:* ___ *yes* ___ *no*

Certifications

I certify that, for each of the days that I request leave, I am unable to work or telework because of one of the 5 reasons listed above.

I certify that the above information is accurate and complete:

Employee Signature: _____ **Date:** _____

Please provide any supporting documentation that you would like the District to consider with your request, for example a copy of the quarantine or isolation order, a note from your health care provider, proof of a school or day care closure, or other documentation, please attach it to this form. Is supporting documentation attached? ☐ Yes ☐ No

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DISTRICT USE ONLY ☐ Approved ☐ Denied

Name _____ Date _____