COUNTY OF GLENN
Families First Coronavirus Response Act
Leave Request and Coordination of Benefits Authorization Form

1. EMPLOYEE INFORMATION:

Employee's Name: _____ DEPT: _____

I am requesting a: ___ Full-Time Leave ____ Part-Time Leave: ___ Hours per Week ____ Hours per Day

From: _____ to _____

I, _____, certify that I am unable to work (or telework) full-time for one of the following reasons:

___ I am requesting a Leave of Absence due to subject to a Federal, State, or local quarantine or isolation order and:

____ (1) having been advised by a health care provider to self-quarantine due to concerns related to COVID-19
____ Yes, I have submitted a Certification of Serious Health Condition Form

____ (2) experiencing symptoms of COVID-19 and seeking medical diagnosis.

____ Yes, I have submitted a Certification of Serious Health Condition Form

___ I am requesting a Leave of Absence to:

____ (3) care for an individual who is subject to a Federal, State or local quarantine or isolation order related to COVID-19 or an individual who has been advised by a health care provider to self-quarantine
____ Yes, I have submitted a Certification of Serious Health Condition of a Family Member Form

____ (4) care for my child whose school or place of care is closed or child care provider is unavailable, due to COVID-19 related reasons
Name and age of child (ren): _____
Name of school or child care provider: _____
Will any other person be providing care for the child (ren)? _____

____ (5) experiencing any other substantially-similar condition that may arise, as specified by the Secretary of Health and Human Services.

***Special Note: All selected elections are final and may not be modified for the duration of the specified leave.**

2. PAY STATUS: At the Onset of This Leave of Absence, I Request the Following Pay Status

_____	I have not/will not apply for wage replacement benefits (State Disability): The leave banks I select below will be used for all my regular work shifts for the duration of my leave. (Required if not receiving wage replacement benefits or if disability benefits are waived)
_____	I request to coordinate my leave bank hours with wage replacement benefits (**State Disability**) up to 100% of base bi-weekly compensation: I understand that I cannot exceed my regular County wages when coordinating my leave banks with State Disability benefits
_____	**Leave Without Pay (LWOP)**: This is a fully unpaid leave, no leave bank hours will be used for the duration of your leave. (Employee's in a LWOP status will not accrue additional leave while in LWOP status.)
_____	I request a leave for reasons **1or 2** above and use 80 hours of **Emergency Paid Sick Leave** (**For reasons 1 or 2 above**, pay will be paid at regular rate of pay up to $511 per day and $5,110 in aggregate.) (Pay Code **3192**)
_____	I request a leave for reasons **3, 4 or 5** above and use 80 hours of **Emergency Paid Sick Leave** (**For reasons 3, 4 or 5 above**, pay will be paid at 2/3 of regular rate of pay up to $200 per day and $2000 in aggregate.) (Pay Code **3195**)
_____	I request a leave for reasons **3, 4 or 5** above and use up to 10 weeks of **Expanded Family Medical Leave Act Pay** (**For reasons 3, 4 or 5** above, pay will be paid at 2/3 of regular rate of pay up to $200 per day and $10000 in aggregate.) (Pay Code **3191**)

Employee Acknowledgment _____ (Employee Initials)	**If your FMLA/CFRA leave becomes unpaid, you will be responsible for submitting your share of the health benefit premium to the Department of Finance by the 10th day of the month preceding the coverage month. If your premium payment is not made in a timely fashion, your group health insurance will be cancelled, provided we notify you in writing at least 15 days before the date that your health coverage will lapse. The same provisions apply to the premium requirements for group dental, vision, and supplemental life insurance plans.**

3. ACCRUAL INFORMATION: Accrual Banks to be Coordinated during a Leave of Absence.

Accruals will be used in the order of Sick Leave, Vacation and then Compensatory Time Off (CTO) if applying for State Disability or Paid Family Leave. Up to 80 hours of Vacation time may kept in the bank if not filing a State Disability or Paid Family Leave claim. Please list any requests regarding accrual usage including if any Annual Leave should be used in the box below.

___ Yes, I would like to coordinate Sick Leave with Emergency Paid Sick Leave or Expanded Medical Leave Act Pay (Available if leave is for reasons 1, 2 or 3 above). **___ Yes, I would like to coordinate Vacation with Emergency Paid Sick Leave or Expanded Medical Leave Act Pay.** **___ Yes, I would like to coordinate Compensation Time off with Emergency Paid Sick Leave or Expanded Medical Leave Act Pay.**
Notes:

Employee Acknowledgement (signature indicates the foregoing statements are true and correct)**:**

I understand that if my circumstances change, I must immediately inform my Department Head or Designee and the Personnel Department and I may be directed to report back to work (or telework).

Employee's Signature: _____Date_____

Department Head/Designee
Acknowledgement: _____ Date: _____

Personnel Director or Designee: _____ Date: _____

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