**Families First Corona Response Act (FFCRA) /  
HRD Alternative Leave Request**

**TO BE COMPLETED BY THE EMPLOYEE:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |  | | Employee ID: |  | |
| Agency/Dept: |  | | Work Location: |  | |
| Position Title: |  | | Supervisor’s Name: |  | |
| Emergency/Core Role: | Yes | No | Telework Approved: | Yes | No |
| Weekly Standard Hours: |  | | Dates Requested: |  | |

|  |
| --- |
|  |
| **I am unable to work or telework for the following reason (check one)** |

I am subject to a Federal, State or local quarantine or isolation order related to COVID-19

|  |  |
| --- | --- |
| **Name of Government Entity issuing quarantine or isolation order**: |  |

I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19

|  |  |
| --- | --- |
| **Name of health care provider**: |  |

I am experiencing symptoms of COVID-19 and seeking a medical diagnosis

I am caring for an individual who is subject to a quarantine, isolation order or health care provider advisory. The need to care for another individual must be genuine (i.e. the individual is unable to care for themselves related to COVID-19)

|  |  |
| --- | --- |
| **Name of health care provider**: |  |

I am caring for my son or daughter because the school or place of care of the son or daughter has been closed, or the child care provider of such son or daughter is unavailable, due to COVID-19 precautions and there is no suitable person available to care for the child during the period of the requested leave.

|  |  |  |
| --- | --- | --- |
| Name of the child being care for: |  | |
| **Name of school, place of care or childcare provider closed/unavailable**: | |  |
|  | | |

I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Employee Signature |  | Date |
|  |  |  |
| Manager Signature |  | Date |

Please send completed form and any additional documentation to the Benefits and Leaves email box at: [EOHHS-BenefitsAndLeaves@MassMail.State.MA.US](mailto:EOHHS-BenefitsAndLeaves@MassMail.State.MA.US).

\*\*\* HR USE ONLY \*\*\*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | | | | | | | |
| Employee Qualifies for: | | |  | |  | |  | |
| PHEL |  | | EPSL |  | HRD Alternative Leave | | Does Not Qualify | |
| Leave Coordinator: | |  | | | | Date: |  |  |
|  | | | | | | | | |