ALAMO HEIGHTS ISD LEAVE REQUEST FORM—
EMERGENCY PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE

Name	**Employee ID**
Department/campus	**Position**
AHISD Email	**Phone number (cell)**
Date	**Duration of leave** *(specify dates requested)*

Leave benefits under the Families First Coronavirus Response Act (FFCRA) expired on 12/31/2020. However, the AHISD board has approved up to 10 days of leave to be used for COVID-related absences. The eligibility criteria is the same criteria used for leave under the FFCRA. The amount of paid leave an employee may receive will vary depending on the reason leave is taken. Detailed information is available in the Employee Rights notice that can be found at www.ahisd.net, under the Staff tab, under COVID sick/quarantine leave.

An employee requesting emergency paid sick leave and expanded family and medical leave must complete this form and return it to Frank Stanage, HR Coordinator, as soon as the need for leave is identified. Documentation supporting the need for leave should be included when the request is submitted.

AHISD Emergency Paid Sick Leave (EPSL) is limited to 80 hours of paid leave at the following rates:

- Self: regular rate of pay up to $511 per day
- For care of an individual or a son or daughter: 2/3rds the regular rate of pay up to $200 per day

AHISD Expanded Family and Medical Leave (EFML) provides up to 80 hours of leave to care for a son or daughter when school is closed or child care is unavailable due to COVID-19. The rate of pay is two-thirds the regular rate of pay up to $200 per day.

I request leave for the following reason(s):

Self

___ I'm subject to a federal, state, or local quarantine or isolation order related to COVID-19.

Name, phone number, and email of entity requiring quarantine or isolation:

____

___ I've been advised to self-quarantine by a health care provider.

Name, phone number, and email of health care provider requiring self-quarantine:

____

___ I'm experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

Name, phone number, and email of health care provider:

____

___ I'm expericing any other substantially-similar conditions specified by the U.S. Department of Health and Human Services.

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Care for other individual or child

___ I'm unable to work in order to care for a minor son or daughter because their school is closed or child care is not available due to COVID-19.

Name, phone number, and email of school or child care facility: ____________________________

Are you the only adult caring for the child(ren): _____yes _____no

Name and age of child(ren): ____

If the son or daughter is over the age of 14 describe special circumstance requiring the care:

____

___ I'm unable to work in order to care for an individual subject or advised to quarantine or isolate.

Name of individual: ___________________________ Relationship: __________________________

Name, phone number, and email of health care provider:

____

Intermittent Leave

___ I'm requesting intermittent leave according to the following schedule:

____

____

Designation *(completed by HR Department and a copy provided to the employee)***:**

_____The employee qualifies for EPSL.

_____The employee does not qualify for EPSL.

_____The employee qualifies for _____ weeks of EFML.

_____The employee does not qualify for EFML.

For office use only:

Date of Employment ______________________

Medical certification provided _____Yes _____ No

Approved by:____
Name and title

Date:_________________