Wellesley Public Schools
Wellesley, MA

Leave Request Form

To request leave on the basis of the Families First Coronavirus Response Act (FFCRA), Americans with Disability Act (ADA) or a discretionary leave, please complete the following request form and submit it to the Human Resources Department as soon as possible.

EMPLOYEE REQUEST

Employee Name:_____ Job Title:_____

Building/Location:_____ Supervisor:_____

Full Time:_____ Part Time:_____ If Part Time, please list FTE:_____

My requested leave is to begin on:_____ and continue through:_____
(date) (date)

Intended Return date:_____
(date)

The reason for this FFCRA leave request is (select the most appropriate box):

☐ I have a bona fide need to care for my child under the age of 18 whose school or place of care is closed due to COVID-19 related reasons. *(The employee is eligible to receive up to twelve weeks paid sick leave at 2/3 their regular rate of pay up to $200 daily and $12,000 total. The employee may supplement payment with up to 15 family sick days from his/her accrued sick time to receive payment for 100% of his/her daily rate, where applicable.)*

Name and age(s) of child(ren): _____
Name of school(s) or place(s) of care: _____

By signing below, the employee certifies that no other suitable person is available to care for the child(ren) during the period of requested leave.

☐ I have been advised by a health care provider to self-quarantine related to COVID-19. *(The employee is eligible to receive up to two weeks of paid sick leave up to $511 daily and $5,110 total for two weeks. The employee may supplement with his/her accrued sick time to receive payment for 100% of his/her daily rate, where applicable.)*

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Name of advising health care provider: _____

☐ Employee is experiencing COVID-19 symptoms and is seeking a medical diagnosis. *(The employee eligible to receive up to two weeks of paid sick leave up to $511 daily and $5,110 total for two weeks. The employee may supplement with his/her accrued sick time to receive payment for 100% of his/her daily rate, where applicable.)*

☐ Employee is caring for an individual subject to a self-quarantine order. *(The employee is eligible to receive up to two weeks paid sick leave at 2/3 regular rate of pay up to $200 daily and $2,000 total for two weeks. The employee may supplement with up to 15 family sick days from his/her accrued sick time to receive payment for 100% of his/her daily rate, where applicable.)*

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Name and relationship of person caring for: _____
Name of government entity issuing the order: _____
OR
Name of advising health care provider: _____

The reason for this discretionary or ADA leave request is (select the most appropriate box):

☐ My own compromised immune system (requires physician ADA form)

☐ A compromised immune system of someone in my home or someone for whom I am the primary caregiver (requires physician certification form)

☐ I do not feel comfortable returning to the school building, so I am requesting an unpaid discretionary leave of absence (does not require any back up documentation)

Comments (Please list any additional details pertinent to your leave request)

_____

_____

_____

All requests for leave under the Families First Coronavirus Response Act must have supporting documentation attached. Failure to provide supporting documentation may slow down the approval process.

I certify that the above information is truthful and understand that misrepresenting my need for leave may be just cause for discipline, up to and including termination.

Employee Signature: _____ Date: _____

For HR use ONLY: Date received: _____

FFCRA approval: _____ ADA/Discretionary Approval:_____

Employee notified on: _____(Date)

By: _____