THE MARYLAND-NATIONAL CAPITAL PARK AND PLANNING
REQUEST FOR PAID LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT FOR EMPLOYEES UNABLE TO WORK OR TELEWORK

Employee Name:	**Employee ID:**
Supervisor's Name:	**Supervisor's Phone Number:**

Employee Status

Merit Employee: Full Time: ☐ works 40hrs/week **or Part-Time:** ☐

Contract Employee: Term ☐ **Seasonal/Intermittent:** ☐ **Temporary (Non-Agency):** ☐

Position Title:	
Home Address:	
Home Phone Number:	**Cell Phone:**
Email Address:	
Anticipated Begin Date of Leave:	**Expected End Date of Leave:**

Per Commission Notice, all employees* may be eligible for:

- Up to 2 weeks of Emergency Paid Sick Leave under the Family First Act.
- Up to 10 weeks of partially paid Sick Leave available under the Emergency Family Medical Leave Expansion Act.

*The new laws permit Merit and Contract (Term, Seasonal/Intermittent, and Temporary) to apply for leave. Please check qualifications as described in the notice before completing this form.

☐ **I attest to the fact that I am unable to work or telework**

I further attest to the fact that I am unable to work (or telework) for the following reason:

1. ☐ I am subject to a federal, state, or local quarantine or isolation order related to COV-ID-19 (EPSL).

Name and phone number of medical care provider: _____
_____
_____

2. ☐ I have been advised by a health care provider to self-quarantine related to COV-ID-19 (EPSL).

Name and phone number of medical care provider: _____
_____
_____

3. ☐ I am experiencing COV-ID-19 symptoms and am seeking a medical diagnosis (EPSL).

Name and phone number of medical care provider: _____
_____
_____

4. ☐ I am caring for an individual subject to a quarantine or isolation order, or who has been advised to self-quarantine (EPSL).
Name and phone number of medical care provider: _____
_____
_____

5. ☐ I am caring for a child whose school or care provider is closed or unavailable due to COV-ID-19 related reasons. (EPSL -First 2 weeks) + (EFMLA- Up to 10 additional weeks)
Name and address of school or care provider: _____
_____
_____

6. ☐ I am experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services. (EPSL)
Name and phone number of medical care provider: _____
_____
_____

Submittal of Request and Supporting Documentation Required
You must submit this request form and any supporting documentation by scanning and sending to the Health & Benefits Office (benefits@mncppc.org).

Supporting documentation for school or care provider closure/unavailability includes a notice that has been posted on a government, school, or day care website, or published in a newspaper or an email from a school official or child care provider. If you provide the name and phone number of the medical provider who issued the quarantine or isolation order, this will be sufficient documentation at this time. Supporting documentation must be submitted within 15 days to the Health & Benefits Office (benefits@mncppc.org). Failure to submit the required documentation may result in the denial of your request for leave.

I certify that the above information is accurate and complete. I understand that if any of the information above is not accurate that my employer may take corrective action.

If I am applying for leave under the Emergency Family and Medical Leave Expansion Act (EFMLA) for the purpose of caring for my child whose school or place of care is closed (or child care provider is unavailable), I understand that the first two weeks will be paid under EPSL regardless of my length of service. I also understand that the additional benefit, up to 10-weeks paid leave, requires employment with the Maryland-National Park and Planning Commission for 30 days. If this applies to me, I further certify that I have been employed with the Maryland-National Capital Park and Planning Commission for at least 30 days.

Employee Signature: _____ **Date:** _____

Health & Benefits Office Signature: _____ Date: _____