Hillsborough County
PUBLIC SCHOOLS
Preparing Students for Life

FFCRA EMERGENCY SICK LEAVE FORM

Name: ____ Lawson Number: _____________

Site: _____________________________________ Position: _____________________________

ELIGIBILITY CRITERIA (please check ***one***)**:**

- ○ I am subject to a federal, state, or local quarantine or isolation order related to COVID-19 (**documentation required). *I understand I will receive 100% of my daily rate of pay for 10 work days. Up to $511 per day.**
- ○ I was advised by a health care provider to self-quarantine due to concerns related to COVID–19 (**documentation required**). ***I understand I will receive 100% of my daily rate of pay for 10 work days. Up to $511 per day.**
- ○ I am experiencing symptoms of COVID-19 and seeking a medical diagnosis (**documentation required**). ***I understand I will receive 100% of my daily rate of pay for 10 work days. Up to $511 per day.**
- ○ I am caring for an individual subject to a federal, state or local quarantine or isolation order or advised by a health care provider to self-quarantine due to COVID-19 concerns (**documentation required**). ***I understand I will receive two-thirds of my daily rate of pay for 10 work days. Up to $200 per day.**
- ○ I am caring for a son or daughter, **under the age of 18**, and the school or place of care of the son or daughter has been closed, or the childcare provider of such son or daughter is unavailable, due to COVID–19. ***I understand I will receive two-thirds of my daily rate of pay for 10 weeks. Up to $200 per day.**
  ADDITIONAL INFORMATION BELOW REQUIRED:
  Name(s) of son(s)/daughter(s): ____
  Name of school/childcare provider that is closed/unavailable: ___________________________
  Verify the statement below by checking the box next to the statement:
  I confirm that no other suitable person is available to care for my child/children.

REQUIRED ADDITIONAL CRITERIA (verify statements below by checking and completing boxes 1-3):

- ○ I **do not** have the option to telework.
- ○ I have worked for HCPS for 30 days or more.
- ○ My requested leave start date is ____________________.
- ○ I would like to use my own accrued time for the other 1/3 daily rate of pay. (Optional for criteria 4 or 5 above)

I certify that the above information is accurate, and that I have attached documentation, if required.

Signature: ___________________________________ Date: _______________

HR USE ONLY

Date Form Received: ____________ Eligible? ______ YES ______ NO

Reason: ____

Date Medical Clearance Letter Received: ____________ HR Dept Rep: ______________________

Revised 05/28/2020