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| **Family First Sick Leave Certification (OVCA3008)** |

**You are eligible for 2 weeks (80 hours for full time employees / equivalent of 2 weeks pro-rated hours for part-time employee) of paid family first sick leave benefits if you have worked for the organization for 30 calendar days.**

NOTE: If you work for an employer with more than 50 employees within a 75 mile radius, and you are requesting **Family First Sick Leave** for your own serious health condition or to take care of a qualifying family members’ COIVD-19 related serious health condition, please complete your company’s existing FMLA/CFRA Medical Leave Certificate Form. **This certificate is to confirm eligibility for the Family First Sick Leave benefit only.**

**This form is to be completed by Medical Provider\* if one of the following criteria is the reason for your leave: #3: II, #3: III, #3: IV or #3:VI** (see below)

1. Employee’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please confirm the reason for the Family First COVID-19 Sick Leave. Check all that apply:
   1. \_\_\_ Subject to self-quarantine/isolation, state or federal mandate: Entity indicating the need for quarantine/isolation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. \_\_\_ **Advised to by health care provider to self-quarantine: Medical provider who issue self-quarantine order \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
   3. \_\_\_ **Experiencing symptoms**
   4. \_\_\_ **Caring for individual subject to criteria in #1 or #2 above** (an immediate family member or a person regularly resides in the home) – or an expectation of care due to the relationship)
   5. \_\_\_ Child Care or School is closed due to COVID-19 (see FMLA Family First Certificate) please provide the name of the child(ren) who is being cared for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   6. \_\_\_ **Experiencing similar condition as specified by the Secretary of HHS**
4. Start Date \_\_\_\_\_\_\_\_\_\_\_ and End Date \_\_\_\_\_\_\_\_\_\_\_ (or approximate date) of requested leave

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Health Care Provider Information: Telephone (\_\_\_) \_\_\_-\_\_\_\_ Fax (\_\_\_) \_\_\_-\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider’s Name Address City State Zip

Signature of Health Care Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\*If you are unable to secure a medical appointment to obtain medical confirmation of your need for COVID-19 sick leave, please read and confirm the following:**

My signature below acknowledges the following statement is true and accurate:

I have attempted and been unsuccessful in scheduling either an in person or internet medical appointment with a medical provider. Name of Healthcare Provider(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I am therefore self-reporting that at this time I am experiencing one or all of the following symptoms: Cough, fever, tiredness, difficulty breathing (severe cases).

At this time I am personally confirming I am unable to work due to the COVID-19 Sick Leave Criteria indicated above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name / Signature of Employee Date