The School Board of Brevard County, 2700 Judge Fran Jamieson Way, Viera, FL 32940-6601

Date: __________

Leave of Absence Request – **COVID-19 ONLY**

☐ Hourly
☐ Contract

Employee ID: ______________

Employee's (Legal) Name: ____________________ **Hours Worked:**____________ **Sch/Dept. #:** ____________________

Job Title: ____________________

Home Address:____________________ **Phone Number:** ______________

Date of Hire: ___________________

Leave Type (To be completed by timekeeper)	Begin Date	End Date	Total Days
COVID-19 Paid Sick Leave ☐ *Medical release needed to return to work (For all scenarios EXCEPT #5)*			
Expanded Family Leave for Childcare ☐ *Up to an additional 10 weeks (For scenario #5 ONLY)*			

I am requesting leave *related to COVID-19* as I am unable to work, including unable to *telework,* because *(circle applicable scenario(s) below and fill in requested data):*

1. I am subject to a Federal, State, or local quarantine or isolation order. Describe order ____________________

2. I have been advised by a Health Care Provider (**HCP**) to self-quarantine.
Name of HCP____________________ Phone number of HCP ______________ Start & End dates of advised quarantine:_________ to __________

3. I am experiencing COVID-19 symptoms and am seeking a medical diagnosis.
Date first experienced symptoms ____________ Date of health care provider (HCP) appt. ______ Name & phone of HCP____________________

The following reasons provide for up to 2 weeks (80 hours, or a part-time employee's 2-week equivalent) of paid sick leave *at 2/3 the regular rate of pay*. If you wish to use your BPS sick or vacation pay to make up the 1/3 of pay, check the noted box*. Note: Scenario #5 can provide an additional 10 weeks of *family leave* at 2/3 regular rate of pay.

4. I am *caring for an individual* subject to an order described in (1) or, will *self*-quarantine as described in (2). [*Circle 1 or 2 at left, then complete 1 or 2 above.*]
* ☐ Use my available sick/vacation pay to make up the 1/3 of pay.

5. I am caring for my child whose school or place of care is closed (or childcare provider is unavailable) due to COVID-19.
Name of child ____________________ DOB __________ ____ Up to 2 weeks paid sick leave _____ Up to 10 weeks paid expanded family leave
Name & phone of childcare provider ____________________
* ☐ Use my available sick/vacation pay to make up the 1/3 of pay.

6. I am experiencing any other substantially similar condition specified by the US Dept. of Health & Human Services. Specified similar condition ____________________
* ☐ Use my available sick/vacation pay to make up the 1/3 of pay.

By signing this form:

- ***I verify that all information I have provided is true and correct and understand that intentionally providing false information will lead to disciplinary action.***
- ***I authorize the BPS school district to contact the noted health care professional(s) only to confirm the information I've provided above, related to a COVID-19 leave.***

Employee Signature ____________________ Date ____________________

Principal/Admin/Supv ____________________ Date____________ Approved? Y N

Leave Department ____________________ Date ____________ Approved? Y N