
S P O K A N E C O U N T Y

HUMAN RESOURCES DEPARTMENT
824 N. ADAMS ST.
SPOKANE, WASHINGTON 99260
TELEPHONE – (509) 477-2127/FAX– (509) 477-6042

Emergency Paid Sick Leave (FFCRA)

Employee Name: _____ Date of Request: _____
Last 4 SSN or ID number: _____ Position Title: _____
Department: _____ Supervisor Name: _____
Leave Start Date: _____ Leave End Date: _____

You may be eligible for Families First Coronavirus Emergency Paid Sick Leave if you have work available, but are unable to work (or telework) due to the need for leave because (check one):

1. I am subject to a Federal, State or local quarantine or isolation order related to COVID-19. Name of government entity that issued the quarantine or isolation order to which you are subject:

2. I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
Name of health care provider who advised you to self-quarantine: _____
3. I am experiencing symptoms of COVID-19 and seeking a medical diagnosis.
4. I am caring for a member of my household or person with whom I have a close relationship (such that it creates an expectation I care for them when they are in need) who is subject to either reasons (1) or (2) above. Name of the individual and their relationship to you:

Name of the government entity that issued the quarantine or isolation order – OR – name of the health care provider who advised the individual to self-quarantine: _____
5. I am caring for a minor child whose school or daycare is closed, or a child care provider is unavailable because of COVID-19 and no other suitable person (generally defined as a co-parent, co-guardian, or usual child care provider) is available to care for the child(ren) during the period of requested leave.

MINOR'S FULL NAME

SCHOOL/DAYCARE NAME

6. I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

In typing my initials below, I attest I have work available, but I am unable to work or telework because of the COVID-19 reason checked above- thereby qualifying me for Emergency Paid Sick Leave. I understand this is a one-time benefit available 4/1/2020- 12/31/2020 and certify I have not previously utilized this leave (with my current or a previous employer). If it is later proven I falsified information, I may be disciplined and may be required to repay any compensation I received. I understand should I fail to return to work from my leave the county may require I repay any benefit premiums paid on my behalf while out on this leave. I understand this Emergency Paid Sick Leave is limited to a total of 80 hours of paid leave. Documentation may be required to support this request.

Employees Initials: _____

Date: _____