City of Oakland

EMPLOYEE CERTIFICATION FOR LEAVE
UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT ("FFCRA")

I certify that I am unable to work for the reason indicated below (please check one) during the time(s) listed below. If am unable to work for reasons 1 or 2, I further certify that I am unable to telework.

☐ 1. I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19. I understand that I will be paid for up to two work-weeks at my regular rate, up to $511 per day and $5,110 in the aggregate. *

Name of the government agency that issued the order: _____

☐ 2. I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. I understand that I will be paid for up to two work-weeks at my regular rate, up to $511 per day and $5,110 in the aggregate. *

Name of the health care provider: _____

☐ 3. I am experiencing one or more COVID-19 symptoms (i.e. fever of 100.4° F or greater, coughing, and/or shortness of breath) and am seeking a medical diagnosis. Once I receive a diagnosis, I may continue using FFCRA leave only if I submit a new certification. For example, if I test positive for COVID-19, I may submit a new certification based on reason number 2 above. While I am seeking a diagnosis, I understand that I will be paid for up to two work-weeks at my regular rate, up to $511 per day and $5,110 in the aggregate. *

☐ 4. I need to care for an individual who is subject to a Federal, State, or local quarantine or isolation order or who has been advised by a health care provider to self-quarantine due to reasons related to COVID-19. I understand that I will be paid for up to two work weeks at 2/3 my regular rate, up to $200 per day and $12,000 in the aggregate. *

My relationship to the individual: _____

Name of the government agency or healthcare provider: _____

☐ 5. I need to care for my child who is a minor or who is incapable of self-care due to a disability and whose school or care-provider is closed or unavailable due to COVID-19 precautions. In addition to this form, I must complete the EMPLOYEE CERTIFICATION FOR EXTENDED FAMILY AND MEDICAL LEAVE ("EFML").

☐ 6. I am experiencing another 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.

Leave start date: _____ Leave end date (if known): _____

I am requesting leave on an intermittent basis: ☐ No ☐ Yes (In addition to this form, I must complete the APPLICATION FOR INTERMITTENT FFCRA LEAVE)

*** I understand that FFCRA leave is subject to caps in pay. I understand that if a cap is lower than my regular rate of pay, I will not be allowed to supplement my FFCRA pay using other leave I may have.**

I understand that if my circumstances change, I must immediately inform my supervisor and I may be directed to report back to work or to telework.

Employee _____ _____ _____
Print name Sign Date

EMPLOYEE CERTIFICATION OF NEED FOR EXTENDED FAMILY AND MEDICAL LEAVE ("EFML") UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT ("FFCRA")

Due to the need to care for my child, I am unable to either work or telework. No other suitable person is available to care for my child during the period of leave. I understand that if my childcare needs change, I must immediately inform my supervisor and the City and I may be directed to report back to work or to telework.

Name of child: _____
Name of school, place of care, or care provider: _____
Reason care is unavailable: _____

Duration of EFML

If approved, I understand that I may take a maximum of twelve work-weeks of EFML. If, however, I have already taken Family and Medical Leave ("FML") this year for other reasons, the amount of EMFL available to me this year is reduced by an equivalent amount.

First Two Work-Weeks of EFML

If approved, I understand that the first two work-weeks of EFML are unpaid unless I elect to concurrently use available Emergency Paid Sick Leave ("EPSL") or another paid leave. If I elect to use Emergency Paid Sick Leave, I understand that I will be paid at 2/3 my regular rate, up to $200 per day and $12,000 in the aggregate.* During the first two weeks of EFML, I will be responsible for indicating on my timecard which paid leave, if any, I elect to use concurrently.

Remaining Work-Weeks of EFML

If approved, I understand that after the first two work-weeks of EFML I will be <u>required</u> to concurrently use any other leave accrual I have that would normally be appropriate for caring for a child who is not ill in accordance with City policy, such as vacation leave, comp time, or management leave. I understand that if I prefer to only use vacation leave, comp time, management leave or similar leave to care for my child, I may apply to do so, without applying to use EFML, in which case I will not be required to use EFML.

> Example: After the first two work-weeks of EFML, I use 5 more days of EFML. If I have five days of vacation, comp time, management leave and/or other appropriate leave, I will be required to use that leave concurrently with my EFML leave and I will be paid for 5 days.

If I have more than one type of appropriate leave available for concurrent use, I will be responsible for indicating on my timecard which leave(s) I prefer to use concurrently. If I run out of other appropriate leave before I run out of EFML I may continue to take EFML until it is exhausted, but I will be paid at 2/3 my regular rate, up to $200 per day and $12,000 in the aggregate.

*** I understand that FFCRA leave is subject to caps in pay. I understand that if such a cap is lower than my regular rate of pay, I will <u>not</u> be allowed to supplement my FFCRA pay using other leave I may have.**

Employee _____ _____ _____
Print name Sign Date

City of Oakland

COVID-19 RETURN-TO-WORK CERTIFICATION

The City has a duty under the law to maintain safe and healthy working conditions for all employees. As part of the City's obligation to provide a safe work environment, if you have tested positive for COVID-19, exhibited symptoms of COVID-19, or are suspected of having or being exposed to COVID-19 due to close contact with a person diagnosed with COVID-19, you may not return to work until you provide a certification from your treating physician that the symptoms are non-communicable or, if that is not practicable, provide one of the certifications below. This requirement is based on the National, State and local declarations of emergency, as well as guidance by the CDC for the prevention of transmission of COVID-19.

Close contact with affected individuals is defined as:

a) being within approximately 6 feet of a person diagnosed with COVID-19 for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a person diagnosed with COVID-19. Close contact for a prolonged period of time may also occur if you come into contact with any person experiencing COVID-19 symptoms for more than 10 minutes; or

b) having direct contact with infectious secretions of a person diagnosed with COVID-19 (e.g., being coughed on);

Check one of the following certifications:

If you tested positive for COVID-19.

☐ I certify I tested positive for COVID-19 more than fourteen (14) calendar days prior to the date of this certification, and I have been free of fever (a "fever" is defined as 100.4° F [37.8° C] or greater using an oral thermometer), signs of a fever, and any other COVID-19 related symptoms (*e.g.*, cough or shortness of breath) for at least fourteen (14) calendar days, without the use of fever-reducing or other symptom-altering medicines (*e.g.*, cough suppressants).

If you exhibited symptoms of COVID-19 or were in close contact with a COVID-19 patient

☐ I certify that I exhibited symptoms of COVID-19 or was suspected of having or being exposed to COVID-19, and that prior to the date of certification I have been free of fever, as defined above, for at least 72 hours without the use of fever-reducing medications, other signs of other COVID-19 related symptoms, including respiratory symptoms (*e.g.*, cough or shortness of breath) have significantly improved in the preceding 72 hours, and that at least 7 days have passed since symptoms first appeared or exposure occurred..

I understand that if I do show further signs of having COVID-19 (e.g., fever, cough, or shortness of breath), I must inform my supervisor immediately and the City of Oakland may require me to undergo a fitness-for-duty examination according to the City of Oakland's policy.

Employee

_____	_____	_____
Print name	Sign	Date

City of Oakland

APPLICATION FOR INTERMITTENT FFCRA LEAVE

I acknowledge that the FFCRA only allows FFCRA leave to be used intermittently where both the employer and employee agree. I further acknowledge that the FFCRA limits the circumstances for which FFCRA leave may be taken intermittently as follows. Non-telecommuting employees may only take FFCRA leave intermittently if they are requesting the leave to care for a son or daughter whose school or place of care has been closed or the childcare provider of the son or daughter is unavailable. Telecommuting employees may take FFCRA leave intermittently for any qualifying reason.

I am requesting to take EPSL on an intermittent basis as follows:

_____

_____

_____

I am requesting to take EPSL on an intermittent basis for the following reason(s):

_____

_____

_____

Employee _____ _____ _____

Print name Sign Date

FOR HUMAN RESOURCES USE:

The "EMPLOYEE CERTIFICATION FOR LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT" and any other documentation related to the request must be retained for 4 years regardless of whether leave is granted or denied.

Request for FFCRA leave Approved: _____ _____

Yes No

Dates of Approved EFMLA: _____

NOTES:

Human Resources Director or Designee

_____ _____ _____

Print name Sign Date