EXTENDED PROGRAM
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. A health care provider advised me 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) <u>and I am seeking a medical diagnosis</u>. Once I receive a diagnosis, I may continue using Extended program leave <u>only if</u> 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 an individual who was 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 EXTENDED PROGRAM INTERMITTENT FFCRA LEAVE)

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

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

EXTENDED PROGRAM
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 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. I also understand that if I have already taken Family and Medical Leave (“FML”) within a rolling calendar year, that 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 EPSL, 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 required to concurrently use any other leave accruals 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 unpaid, like regular FML.

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

Employee ___________________________ ___________________________ _____________

Print name | Sign | Date

COVID-19 RETURN-TO-WORK CERTIFICATION

The law requires the City to maintain safe and healthy working conditions for all employees. To maintain City-wide health and safety, if you tested positive for COVID-19, exhibited symptoms of COVID-19, or were possibly exposed to COVID-19 due to Close Contact, 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 below certifications. 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 means an individual who has been within 6 feet of the positive individual for at least 15 cumulative minutes over a 24-hour period within 48 hours of the positive individual displaying symptoms or testing positive.

Check one of the following certifications:

If you tested positive for COVID-19.

[ ] I certify that I tested positive for COVID-19 and that I had no symptoms. I also certify that 10 days have passed since the sample collection date of my positive COVID-19 test which resulted in a positive result.

[ ] I certify that I tested positive for COVID-19 and that I was symptomatic. I also certify that at least 24 hours have passed since I had fever of 100.4 without the use of fever-reducing medications, that my COVID-19 symptoms have improved, and that at least 10 days have passed since my COVID-19 symptoms first appeared.

If you did not test positive for COVID-19

[ ] I certify that I was exposed to a COVID-19 positive individual through Close Contact. I also certify that 10 days have passed since I was last exposed and that I have developed no COVID-19 symptoms.

I understand that if I do show new or additional 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 additional steps before I am allowed to return to on-site work.

Employee ___________________________ ___________________________ _____________

Print name | Sign | Date

EXTENDED PROGRAM
APPLICATION FOR INTERMITTENT FFCRA LEAVE

I acknowledge that the Extended Program only allows Extended Program leave to be used intermittently where both the employer and employee agree. I further acknowledge that the Extended Program limits the circumstances for which Extended Program leave may be taken intermittently as follows. Non-telecommuting employees may only take Extended Program 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 Extended Program leave intermittently for any qualifying reason.

I am requesting to take Extended Program leave on an intermittent basis as follows:

____

____

____

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

____

____

____

Employee	______________________	______________________	__________
	Print name	Sign	Date

FOR HUMAN RESOURCES USE:

The Extended Program Leave Certification Form and any other documentation related to the request must be retained for 4 years regardless of whether leave is granted or denied.

Request for Extended Program leave Approved: ________ Yes ________ No

Dates of Approved EFMLA: ____________________

NOTES:

Human Resources Director or Designee

_________________________	_________________________	____________
Print name	Sign	Date