Families First Coronavirus Response Act Claim Form

Effective April 1, 2020 - December 31, 2020

Seedorff Companies

408 W Mission St
Strawberry Point, IA 52076
563-933-2296

Employee Information

Name		Supervisor	
Address	City	State	Zip Code
(Area Code) Phone Number	Job Title	Average # of Hours Worked per Week:	

Part 1 - Emergency Paid Sick Leave - Provides employees with two-weeks of paid sick leave.

Is this claim for one or more of the following situations?:
Mark all that apply.

☐ (1) Subject to a government quarantine or isolation order related to COVID-19 Name of entity that issued order _____

☐ (2) Have been advised by health provider to self-quarantine due to COVID-19

☐ (3) Experiencing symptoms of COVID-19 and seeking medical diagnosis Describe steps being taken _____

☐ (4) Caring for an individual subject to quarantine order described in (1); or self-quarantine, described in (2) Name/relationship _____

☐ (5) Caring for his or her child if schools are closed or his or her caregiver is unavailable because of a public health emergency (Complete Part 2)

☐ (6) Experiencing substantially similar conditions as specified by the Secretary of Health and Human Services

Nature of illness and when symptoms first appeared.		Anticipated Return Date (Mo.)/(Day)/(Year)
Date of illness (1st Day Absent) (Mo.)/(Day)/(Year)	Date of Diagnosis (Mo.)/(Day)/(Year)	Physician and Clinic Name

Part 2 - Paid Family and Medical Leave - Provides employees with up to 12 weeks of FMLA

This paid family and medical leave is available to any employee who has been employed for at least 30 days if they are unable to work, including unable to telework, because the employee is caring for his or her child whose school or place of care is closed or unavailable because of a public health emergency.

When did school or childcare end?(Mo.)/(Day)/(Year) _____ Provide closure notice from entity

What is the anticipated return date?(Mo.)/(Day)/(Year) _____ Is there another suitable adult able to care for child(ren)? _____

Name and age of child(ren):

How do you wish to cover the 10-day waiting period?	☐ Paid	☐ EPSL	☐ Unpaid			
Will FMLA be taken intermittently? If yes, provide schedule. Y / N	If you selected paid, please enter the number of vacation and/or sick days that will be used.		Vacation Days:		Sick Days (Non-union only):	

Employee Signature Line

The information is true and complete to the best of my knowledge and belief.

Employee Signature	Date
Form Completed By (Print)	Date

For Office Use Only:

FFCRA - Paid Sick Leave Average daily hours (past 6 months):				
Timeperiod reviewed:	Beginning date:		Ending date:	
FFCRA-Paid FMLA	Beginning date:		Ending date:	
Approval/Date:				

Notes: