EMPLOYEE RIGHTS

PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

The **Families First Coronavirus Response Act (FFCRA or Act)** requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

▸ PAID LEAVE ENTITLEMENTS

Generally, employers covered under the Act must provide employees:

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- ⅔ for qualifying reasons #4 and 6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at ⅔ for qualifying reason #5 below for up to $200 daily and $12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

▸ ELIGIBLE EMPLOYEES

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). *Employees who have been employed for at least 30 days* prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

▸ QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19

An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to **telework**, because the employee:

1. is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
2. has been advised by a health care provider to self-quarantine related to COVID-19;
3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
5. is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
6. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

▸ ENFORCEMENT

The U.S. Department of Labor's Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

For additional information or to file a complaint:
1-866-487-9243
TTY: 1-877-889-5627
dol.gov/agencies/whd

WH1422 REV 03/20

Please submit via email

Shelby County Schools
EMERGENCY PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

All completed leave requests must be accompanied by appropriate documentation as required in the Board policies of Shelby County Schools and submitted via email to the Office of Employee Benefits, at least thirty (30) days in advance or as soon as possible.

Name_____ Social Security Number _____ - _____ - _____ Date___/ ___/___

Any correspondences regarding this Leave of Absence request will be mailed to the address Shelby County Schools has on file. It is your responsibility to ensure your records are current at all times.

Home Phone ( ) _____ - _____ Alt. Phone ( ) _____ - _____ Current Assigned Location Name_____
Current Assigned Position_____

Type of Leave:

_____ **Unable to work due to Federal/State/Local quarantine**

_____ **Unable to work due to being advised by a healthcare Provider to self-quarantine**

_____ **Unable to work due to COVID symptoms/seeking diagnosis**

_____ **Unable to work due to caring for an individual impacted by Covid-19**

_____ **Unable to work due to child's school/place of care closure**

_____ **Unable to work due to experiencing any other similar condition specified by the U.S. Department of Health and Human Services**

NOTE TO TEACHERS/INSTRUCTIONAL EMPLOYEES:
If leave is taken more than five (5) weeks prior to the end of the semester, and the return to employment is within three (3) weeks of the ending semester, the teacher will not be able to return until the first day of the next semester.
If leave is taken five (5) weeks prior to the end of the semester, and the return to employment is within two (2) weeks of the ending semester, the teacher will not be able to return until the first day of the next semester.

If the return to work date is within three weeks of the end of the semester, the teacher will not be able to report to work until the first day of the next semester. (See Leave Administrators for the actual deadline date for each semester.)

Requested date for leave to begin ___/___/___
(First Day of Consecutive Absence)

Requested date to return to work ___/___/___

***** If you are on an approved leave of absence and go into unpaid status, you will receive a monthly invoice for the employee portion of medical, dental, vision, basic life, and long-term disability until your return to active employment. Failure to receive an invoice does not relieve you from your responsibility of making timely premium payments.**

NOTE to Employee: **You are required to report to the Office of Employee Benefits five (5) business days prior to the expiration of your approved leave to receive a written clearance to give to your supervisor.**
*****If any portion of your Leave of Absence is unpaid and you are returning prior to the end of the current school year, upon your return to work your salary will be recalculated (lowered) due to the number of scheduled workdays and pay periods remaining in the school year (excluding hourly employees).**

_____ Date ___/___/____
Signature of Principal/Supervisor *(Required)*

_____ Date ___/___/____
Signature of Employee *(Required)*

I, ***the employee***, agree to abide by the Federal and State laws and leave policies, rules and regulations of Shelby County Schools regarding the policy under which I am requesting leave.

HUMAN RESOURCES ONLY

____ **Approved** _____ **Denied** **Approved Leave Dates**: Beginning _____/_____/_____ Ending _____/_____/_____

FMLA Dates: Beginning ___/___/____ Ending ___/____/___ Number of FMLA Days used:_____

NON- FMLA Dates: Beginning ___/___/___ Ending ___/___/___ Number of Vacation Days used: _____

PAID STATUS: Beginning ___/___/___ Ending ___/___/___ **UNPAID STATUS**: Beginning ___/___/___ Ending ___/___/___

Approved by: _____ Date Approved _____/_____/_____
Signature of Leave Administrator

Leave Extension Dates
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____
_____/_____/_____

Revised

EXPANDED FAMILY MEDICAL LEAVE/ EMERGENCY SICK LEAVE
CARES ACT (COVID-19)

Employee Checklist

1. Visit the Shelby County School's website at www.scsk12.org

- Click on Employees
- Click on Benefits
- Click on Leave of Absence
- FFCRA Covid 19 Leave Packet

2. Complete the required documents.

3. Submit your request via email to your assigned Leave of Absence Administrator for processing. Leave requests must be accompanied by the appropriate documentation and submitted at least thirty (30) days in advance or as soon as possible.

Expanded Family Medical Leave

☐ *Leave of Absence Request form (signed by manager/administrator)*

☐ *If you request leave to care for your child whose school or place of care is closed, or childcare provider is unavailable, you must provide:*

- *The name of your child*
- *The name of the school, place of care, or childcare provider that has closed or become unavailable*
- *A statement that no other suitable person is available to care for your child*
- *You must provide written documentation to support your leave request (indicating the estimated beginning and return to work date)*

Emergency Paid Sick Leave

☐ *Leave of Absence Request form (signed by manager/administrator)*

☐ *Government Entity Notice- If you request leave because you are subject to a quarantine or isolation order or to care for an individual subject to such an order, you should provide the name of the government entity that issued the order.*

☐ *Health Care Provider Statement- A Health Care Provider statement is required for the following:*

- *is subject to a Federal, State, or local quarantine or isolation order related to COVID-19*
- *has been advised by a health care provider to self-quarantine related to COVID-19*
- *is experiencing COVID-19 symptoms and is seeking a medical diagnosis*
- *caring for an individual who is subject to quarantine or isolation order*

Note: *Continuous/consecutive absences - an* ***estimated*** *beginning and return to work date is required by the health care provider or government entity.*

Leave Administrators:
Marvay Mosley - Locations A-K
Office: 901-416-5869
Email: mosleyml@scsk12.org

Dana Jackson Dortch - Locations L-Z
Office: 901-416-5514:
Email: jacksond1@scsk12.org

RETURNING TO WORK FROM LEAVE:

A Reinstatement form must be submitted and reviewed for approval prior to returning to work. You must also provide a letter from your physician indicating you are able to return to work.

Please submit all required documents via email.

Please submit via email

Shelby County Schools
Department of Human Resources
Office of Employee Benefits

REINSTATEMENT FORM

Emergency Paid Sick Leave and Expanded Family and Medical Leave
Families First Coronavirus Response Act

I understand that prior to my return from leave and reporting to my assigned location, I must email this form to my assigned Leave Administrator. This form must be signed by the Leave Administrator for written clearance.

I understand that I must provide a letter from my physician indicating that I have been cleared to return to work.

If you have been released by your physician to return to work with restrictions; you must submit a statement from your physician identifying the limitations and the timeframe (specific dates) in which limitations are effective.

I understand by signing this form, I have read and understand the terms of condition for returning to work from my approved leave of absence. **Additionally, I understand that failure to comply may result in a delay of the processing of my leave return which could affect my paycheck or employment status.**

Please Print:

Employee's Name: _____ Last 4 digits of SSN: _____

Current Location Name: _____ Current Job Title: _____

Date to Return to Work: _____ / _____ / _____

_____ _____ / _____ / _____
Employee's Signature **Today's Date**

_____ _____ / _____ /_____
*(Required)***Leave Administrator's Signature (The Office of Employee Benefits)** **Today's Date**

CC: Principal/Supervisor