AGC Biologics

COVID-19 MAJOR DISASTER SHARED LEAVE REQUEST FORM

INSTRUCTIONS: Complete ths form and submit with attachments to your Manager, then Human Resources; you will be notified by Human Resources if shared leave is available, if your request is approved, and the number of hours awarded.

TO BE COMPLETED BY REQUESTING EMPLOYEE

Check the reason you are requesting shared leave and provide any additional information requested:

1. ☐ I am subject to a Federal, State or Local quarantine order related to COVID-19; I have exhausted all paid leave, and am unable to work from home

2. ☐ I am at "high risk" due to age or underlying health condition and have been advised by my healthcare provider to self-quarantine; I have exhausted all paid leave, and am unable to work from home. (Please attach a Certification of Health Care Provider form.)

3. ☐ I am experiencing symptoms, am seeking medical treatment and/or have been diagnosed with COVID-19 and have been advised by my healthcare provider to quarantine; I have exhausted all paid leave, and am unable to work from home. (Please attach approved FMLA request OR, if not eligible due to hours worked/service requirements, please attach a Certification of Health Care Provider form.)

4. ☐ I am caring for an immediate family member who is diagnosed with COVID-19 and is subject to quarantine; I have exhausted all paid leave, and am unable to work from home. (Please attach approved FMLA request OR, if not eligible due to hours worked/service requirements, please attach a Certification of Health Care Provider form.)

5. ☐ I am caring for my own children (under the age of 15) whose school of child care is closed/unavailable due to COVID-19; I have exhausted all leave and am unable to work from home

How long do you expect to be off work (if known)? From: _____ To: _____

Do you expect to use shared leave intermittently (you are working a reduced schedule)? ☐Yes ☐No

If yes, please describe your anticipated work schedule and the length of time the schedule will be in place:

How many hours of shared leave are you requesting? _____

Please confirm the following statement by checking the box below

☐ Per my request above and as indicated by my signature, I will have to take leave without pay or terminate employment as I do not have sufficient paid leave to cover my absence from work. I have read the COVID-19 Major Disaster Shared Leave policy and understand the terms and conditions of receiving donated leave.

Name	Signature	Date

TO BE COMPLETED BY EMPLOYEE'S MANAGER

Employee will be provided with work from home options (if applicable) ☐Yes ☐ No

If Yes, please include # of hours/week _____ and duration (thru) _____

Name	Title	Signature	Date

TO BE COMPLETED BY HUMAN RESOURCES

Shared Leave is approved ☐ Yes ☐ No

If no, reason for denial _____

Approved # of Hours_____	Leave Begin Date_____	Leave End Date_____

Name Title

Signature

Human Resources: Upon approval, notify the requesting employee