



FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA) FLEXIBLE WORK ARRANGEMENT REQUEST

Employee Name: _____ Employee ID#: _____

Supervisor Name: _____ Department: _____

SPECIAL PROVISIONS UNDER FFCRA (April 1, 2020 to December 31, 2020)

_____ **I fall into one (1) or more of these six (6) categories that are covered by FFCRA for COVID-19:**

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

CDC RECOMMENDATIONS (none of the bullet points below guarantee a work adjustment)

_____ **I fall into one (1) or more of these categories:**

- I have a medical condition that is high risk per CDC guidelines.
 - People 65 years and older
 - People who live in a nursing home or long-term care facility
 - People of all ages with underlying medical conditions:
 - Chronic lung disease or moderate to severe asthma
 - Serious heart conditions
 - Immunocompromised
 - Severe obesity (BMI of 40 or higher)
 - Diabetes
 - Chronic kidney disease undergoing dialysis
 - Liver disease
- A high risk individual lives with me in my home.

OTHER CATEGORIES (none of the bullet points below guarantee a work adjustment)

_____ I fall into one (1) or more of these categories:

- I do not want to return to work on the campus due to a clinical diagnosis or other medical condition other than what is outlined in the FFCRA or as COVID-19 high risk per CDC guidelines.
- I do not want to return to work on campus because I am worried about catching COVID-19 from a person on campus.
- I do not have adult/day care for my dependent or elderly family member who lives with me.

POSSIBLE WORK OPTIONS (ADJUSTMENTS) (select a maximum of two options)

I am requesting the following work adjustment(s):

_____ Adjustment to my work schedule on campus.

_____ Change campus locations.

_____ Permission to telecommute occasionally (1-3 days per week).

_____ Permission to telecommute regularly (4-5 days per week).

_____ Other (Please Provide Details):

EMPLOYEE UNDERSTANDS AND AGREES TO THE FOLLOWING:

- ✓ I understand I do not make an adjustment to my work schedule or work location on my own. Any adjustment to the conditions of my employment must be provided by and approved by Human Resources and my supervisor.
- ✓ I understand that filling out and submitting this form to Human Resources is not a guarantee of any adjustment to my work schedule or work location.
- ✓ I understand that I may be required to provide proof of my specific situation in order to receive an adjustment to my work schedule or work location.
- ✓ I understand that if I am not FFCRA eligible that I may not receive a work adjustment (CSN is not obligated to offer a work adjustment without eligibility in a federal or state program).
- ✓ I understand that if I fall below twenty (20) hours per week of paid work or leave, I may no longer be eligible for medical and/or retirement benefits.
- ✓ I understand that the provisions in FFCRA end December 31, 2020, and that any work adjustment I may receive may end on December 31, 2020, or prior to that date based on department, student, or College need, or a written doctor's notice.

- ✓ I understand that I may be required to submit a return to work note from a medical professional when the work adjustment ends and I am expected to return to work, either on campus or at another location.

Employee Signature

Date

Please submit this form to the Benefits Coordinator in Human Resources at CSN – Kathryn.Eghoian@csn.edu. Submission of this form will initiate a discussion with Human Resources and the employee’s immediate supervisor and/or department. HIPAA and other applicable laws and policies will be followed.

INSTRUCTIONS ON HOW TO SUBMIT TO HUMAN RESOURCES

You must print the document and complete and sign it, then send it to Kathryn Eghoian, Benefits Coordinator in Human Resources

Sending Options:

1. Scan to Kathryn.Eghoian@csn.edu .
 - a. There is scanning software in Adobe (Adobe Scan) or you can download a free document scanning app from your app store.
2. Take a picture of each page and attach each picture to an email to Kathryn.Eghoian@csn.edu .
3. Place in the postal mail (Caution – this will add time to the response from Human Resources). Send to:
 - a. Kathryn Eghoian
Benefits Coordinator – Human Resources
College of Southern Nevada
6375 W. Charleston Blvd., E-411
Las Vegas, NV 89146
(702) 651-7457 Office
(702) 651-7659 Confidential Fax

Human Resources recommends maintaining a copy of this completed document for your records and saving your email submission.