NATIONAL BUREAU OF ECONOMIC RESEARCH
FAMILIES FIRST CORONAVIRUS RESPONSE ACT CERTIFICATION FORM

The Families First Coronavirus Response Act ("FFCRA") provides that employees of certain employers are eligible for certain paid sick leave and expanded family and medical leave between April 1, 2020 and December 31, 2020 for specified reasons related to COVID-19. You may qualify for paid sick time of up to two weeks if you are unable to work (or telework) due to any of the reasons listed below (at full pay for reasons #1-3, up to $511 daily and $5,110 total or two-thirds pay for reasons #4-6 up to $200 daily and $2,000 total). If you are unable to work (or telework) due to reason #5, you may also qualify for expanded family leave of up to twelve weeks (at two-thirds pay up to $200 daily and $10,000 total, except for the first two weeks which are unpaid unless you elect to substitute any paid sick time available to you under FFCRA or other accrued leave). **Please check which reason(s) applies to you and provide any additional information requested below.**

If you need to take leave beyond the two weeks of emergency paid sick leave under the FFCRA because your medical condition (or the medical condition of your family member) for COVID-19-related reasons rises to the level of a serious health condition, you will be required to submit additional medical certification in accordance with the Family and Medical Leave Act. For copies of the relevant certification form, please contact Diane Birnbaum at hr@nber.org.

Qualifying Reasons	Required Documentation
☐ 1. Subject to a Federal, State, or local quarantine or isolation order related to COVID-19.	Copy of the Federal, State or local quarantine or isolation order related to COVID-19 applicable to you.
☐ 2. Advised by a health care provider to self-quarantine related to COVID-19.	Written documentation by a health care provider, including the health care provider's name, advising you to self-quarantine due to concerns related to COVID-19.
☐ 3. Experiencing COVID-19 symptoms and is seeking a medical diagnosis.	Written documentation by a health care provider, including the health care provider's name, confirming that you sought a medical diagnosis in relation to COVID-19 symptoms.
☐ 4. Caring for an individual subject to an order described in (1) or self-quarantine as described in (2). Name of individual: _____	• Copy of the Federal, State or local quarantine or isolation order related to COVID-19 applicable to such individual; **OR** • Written documentation by a health care provider, including the health care provider's name, advising such individual to self-quarantine due to concerns related to COVID-19.
☐ 5. Caring for a child whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19. Name of child: _____ Date of birth: _____ Intermittent/reduced schedule requested: ☐ No ☐ Yes[1]	Notice of closure or unavailability from your child's school, place of care, or child care provider, such as a notice posted on a government, school, or day care website, published in a newspaper, or emailed to you from an employee or official of the school, place of care, or child care provider.
☐ 6. Experiencing any other substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.	Written documentation of qualifying conditions, as may be specified by the Department of Labor or otherwise determined by your employer.

☐ I hereby elect to substitute any partially-paid or unpaid portion of any leave entitlement above with any accrued vacation leave, personal leave, medical or sick leave (including, as applicable, any paid sick leave entitlement under reason #5 for the first two weeks of expanded family leave).

☐ **I hereby certify that (a) all of the information provided on this form is true and complete, and (b) I am unable to work (or telework) due to the designated reason(s) above and therefore request leave from approximately _____ to _____.**

Signature _____ Print Full Name _____ Date _____	**For NBER Use Only:** Employee Hire Date: _____ Required Documentation Provided: ☐ Leave Approved ☐ Not Approved ☐

1 Please attach proposed intermittent leave schedule with supervisor approval.