American Payroll and Benefits I, LLC
PO Box 189 Ocala, FL 34478
Phone: 352-624-1999 Fax: 352-342-9356

COVID-19 NOTICE OF LEAVE QUALIFYING STATEMENT

Client Name: _____

Employee Name: _____ **SSN:** _____

Address: _____

City: _____ **State:** _____ **Zip:**_____

I, _____, hereby give notice of leave under the Families First Coronavirus Response Act (FFCRA). By initialing **ONE OR MORE** of the following, I am certifying that I am eligible based on the qualifying scenario(s) selected:

*EMPLOYEE MUST *INITIAL* EACH QUALIFYING REASON THEY ARE ELIGIBLE FOR*

_____ 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 getting a COVID-19 vaccine, or recovering from adverse reactions to the vaccine;

_____ 5. is awaiting the results of a COVID diagnosis or test after having close contact with a person with COVID-19 or at the employer's request;

_____ 6. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);

_____ 7. 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

_____ 8. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

I understand that additional documentation may be required of me, as applicable and allowed by law including Wage and Hour, Department of Labor, IRS, or other entity. Any person who knowingly and with intent to injure, defraud, or deceive any files, statement of claim, or an application containing any false, incomplete, or misleading information or conceal information pertinent as relevant to payments and monies under the FFCRA, may be found guilty and punished as provided under the law.

Employee Signature: _____ **Date**:_____