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May 18, 2020

**DEPARTMENT OF ADMINISTRATION ORGANIZATIONAL CIRCULAR NO.: 2020-020**

MEMORANDUM

To: All Line Department and Agency Heads  
From: Director, Department of Administration  
Subject: **Family First Coronavirus Response Act  
RE: Expanded Family Medical Leave**


***Buenas yan Håfa Adai!*** In response to the Novel Coronavirus (COVID-19) pandemic and its impact on the nation's workforce, the Families First Coronavirus Response Act (FFRCA) was signed into law effective April 1, 2020, through December 31, 2020, which amends Title I of the Family and Medical Leave Act, 29 U.S.C. 2601 et seq. (FMLA), permits employees to take leave for the following reasons:

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

The FFRCA included an extension of the FLMA Act to allow twelve (12) weeks of leave for employees to care for their children when their school or daycare is closed to due to COVID-19 concerns and there is no suitable person to provide such care. As with regular FMLA leave, the employee must first exhaust accrued leave that would be otherwise applicable. Therefore, you may opt to utilize your own accrued annual or sick leave to cover this period, to include "leave share".

Employees utilizing accrued leave shall receive their equivalent of their full day's wages accordingly. In addition, employees utilizing leave under the FFCRA are required to utilize the attached leave form, which is a temporary form specifically to capture leave for the categories referenced above.

Should you have any questions, please contact the Department of Administration, Human Resources Division at 475-1288 or 475-1141. ***Dangkolo na Agradesimiento!***



EDWARD M. BIRN

Attachment



## FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFRCA) (COVID-19) FAMILY MEDICAL LEAVE ACT REQUEST

**Instructions:** Please complete and submit form to your immediate supervisor and appropriate Administration/Appointing Authority.

SECTION A: TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT CLEARLY OR TYPE)					
Date of Request:		Department:			
Employee ID No.:		Employee Name: (Last, First, MI)		Contact Number:	
Address while on leave (Include city, state and zip code):					
Position Title:			Work Schedule:		
Leave Begin Date: (Include time)		Leave End Date: (Include time)		Total Hours Requested:	
Last Day Physically at Work:			Expected Return to Work Date:		
I certify the following information is true and accurate: (Check appropriate boxes)					
<p>The Family First Coronavirus Response Act (FFCRA), amends the Family and Medical Leave Act (FMLA), to include provisions for employees off work for reasons relating to the Coronavirus/COVID-19 disease, and is applicable to government of Guam employees <b>effective April 1, 2020 through December 31, 2020</b>. As with regular FMLA Leave, employees must first exhaust their accrued leave that would otherwise be applicable.</p>					
<input type="checkbox"/> (a) I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19. (EO 20-03 and particularized orders such as, I am required to quarantine myself after travel or residing with someone or presumed positive for COVID-19) Duration of Order: ____ days.					
<input type="checkbox"/> (b) I have been advised by a health care provider to self-quarantine, due to COVID-19.					
<input type="checkbox"/> (c) I am experiencing COVID-19 symptoms and I am seeking a medical diagnosis. <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> Under (c), I acknowledge I must remain off work continuously until I meet BOTH criteria below:</li> <li><input checked="" type="checkbox"/> At least three (3) days (seventy-two (72)) hours have passed since recovery; defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath) and;</li> <li><input checked="" type="checkbox"/> At least seven (7) days have passed since symptoms first appeared or I was last in the workplace, whichever occurred later.</li> </ul>					
<input type="checkbox"/> (d) I am caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19 <i>or</i> has been advised by a health care provider to self-quarantine due to COVID-19 concerns.					
<input type="checkbox"/> (e) I am caring for my child under of the age eighteen (18) or with a disability, under the Americans with Disabilities Act (ADA), because the school or place of care of the child has been closed or is unavailable, due to COVID-19. Please provide information below:					
<b>Name of Child</b>		<b>Name of School or Daycare Provider</b>		<b>Telephone Number/Email Address</b>	
<p>I certify the truth and veracity of the above attestations and that I have made a reasonable inquiry to confirm the accuracy therefore. I further certify that I have not made a material false statement with the intent to mislead a public servant in the performance of his or her official functions. I understand that I may be subject to disciplinary action, including dismissal, if any of the above is subsequently determined to be false or misleading.</p>					
Employee Signature:					Date:
SECTION B: IMMEDIATE SUPERVISOR					
<input type="checkbox"/> Approved	<input type="checkbox"/> Disapproved	Immediate Supervisor's Signature:		Date:	
Annual Leave Balance:		Sick Leave Balance:		Compensatory-Time Off (CTO) Balance:	
SECTION C: DIVISION HEAD					
<input type="checkbox"/> Approved	<input type="checkbox"/> Disapproved	Division/Section Head's Signature:		Date:	
SECTION D: APPOINTING AUTHORITY					
<input type="checkbox"/> Approved	<input type="checkbox"/> Disapproved	Appointing Authority's Signature:		Date:	