Aurora
Mental Health
Center Live Life to the Fullest

1290 Chambers Road
Aurora, CO 80011
303.617.2300
aumhc.org

Health Families and Workplaces Act (HFWA) Leave Documentation Form
July 15-December 31, 2020

If you are requesting leave under the HFWA please complete Section I and return to HR@aumhc.org

Section I

Date: ______________

Name (Please print):____

Please select the reason you are requesting Sick leave under the HFWA:

☐ I have COVID-19 symptoms and am seeking a medical diagnosis

☐ I am being advised by a governmental agency (state, federal, local), or advised by a medical provider, to quarantine or isolate due to risk of COVID-19.

☐ I am taking care of someone else due to COVID-19 precautions – either someone ordered to quarantine or isolate,* or a child whose school, place of care, or childcare is closed or unavailable.

Start Date of Requested Leave: _____________________________

End Date of Requested Leave: ______________________________

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Please complete the following corresponding information:

Name and Phone Number of Health Care Provider:	
Governmental Agency Requiring Isolation/Quarantine:	
Name and Number of Childcare Provider:	
Name and Number of School:	

*If leave is to provide childcare, are you the only suitable person available?

______Yes   _______No

If yes, please provide reason:

____
____
____
____

____
Employee Signature

_________________________________   ____________________
Printed Name   Date

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Section II (HR Use Only)

Full-Time (1.0)		Hours Per Week:	
Regular PT EE:		Hours Per Week:	
PRN/PT/Variable Schedule:		Average Hour Per Week:	
Start Date:		Average Hours Per Week if 6 months or less of employment:	