COVID-19 Emergency Sick Leave

Name:____ Date:_______________________________

Cell Phone: ____ Email: _______________________________________

I hereby certify that I need to use Emergency Paid Sick Leave because I cannot work or telework for one of the following reasons (CHECK ONE):

Emergency Sick Leave for Employee's Own Situation

_______ I am unable to work/telework because I am subject to a governmental quarantine or isolation order due to COVID-19 related concerns.

Name of Governmental Entity Issuing Order: ____

_______I am unable to work/telework because I am experiencing symptoms of COVID-19 and seeking medical diagnosis.

Name of Health Care Provider:____

_______I am unable to work/telework because I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

Name of Health Care Provider: ____

_______A leave under this provision will provide you with your regular pay for 80 hours/2 weeks to a maximum of $511 per day or $5,110 total. I request that my accumulated time (sick/personal/vacation) if applicable, be used to make up the difference so that I receive my full pay

Emergency Sick Leave to Care for an Individual

_______I am unable to work/telework because I am required to care for an individual (not a son or daughter or foster child) who is subject to a governmental quarantine or isolation order.

Name of Individual:__________________________________Relationship:_________________________

Name of Governmental Entity Issuing Order: ____

______ I am unable to work/telework because I am required to care for an individual (not a son or daughter or foster child) who has been advised to self-quarantine due to concerns related to COVID-19.

Name of Individual: ____ Relationship: ___________________________

Name of Health Care Provider:____

_______A leave under this provision will provide you with 2/3 of your regular pay for 80 hours/2 weeks to a maximum of $200 per day or $2,000 total. I request that my accumulated time (sick/personal/vacation) if applicable, be used to make up the difference so that I receive my full pay.

First Date of Leave: ______________________________ Anticipated Return to Work Date: ___________________________

I understand that I may be required to provide additional documentation and/or a fitness to return to work certification. I acknowledge that it is my responsibility to contact _______________ at _________________ prior to returning to work. I also understand that if I am unable to return to work/telework on the above date. I must obtain approval for an extension of my leave. I certify that the information provided herein is accurate and true.

Signature:____Date:_________________________________

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