EMERGENCY PAID SICK LEAVE REQUEST AS ENTITLED BY THE FAMILIES FIRST CORONAVIRUS ACT

EMPLOYEES WHO ARE UNABLE TO WORK (OR TELEWORK) FOR A REASON THAT QUALIFIES FOR EMERGENCY PAID SICK LEAVE (EPSL) PURSUANT TO THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA) MUST COMPLETE THIS FORM. YOU MUST PROVIDE AS MUCH ADVANCE NOTICE AS IS REASONABLY PRACTICABLE.

UPON COMPLETION OF THIS FORM, SUBMIT TO _____ FOR REVIEW, APPROVAL AND PROCESSING.

EMPLOYEE NAME: _____PHONE NUMBER: _____

EMPLOYEE HOME ADDRESS:_____ E-MAIL: _____

ANTICIPATED START DATE OF LEAVE: _____ EXPECTED END DATE OF LEAVE: _____

(MAXIMUM EPSL FOR FULL-TIME EMPLOYEES WORKING 40 HOURS/WEEK IS 80 HOURS. PART-TIME EMPLOYEES (UNDER 40 HOURS) ARE ENTITLED TO A MAXIMUM AMOUNT OF EPSL EQUAL TO THEIR AVERAGE WORK HOURS OVER A TWO-WEEK PERIOD.)

REASON FOR LEAVE (*CHECK ALL APPLICABLE*): I AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASONS:

____ I AM SUBJECT TO A FEDERAL, STATE OR LOCAL QUARANTINE OR ISOLATION ORDER RELATED TO COVID-19.

____ I HAVE BEEN ADVISED BY A HEALTH CARE PROVIDER TO SELF-QUARANTINE DUE TO CONCERNS RELATED TO COVID- 19. ***HEALTH CARE PROVIDER'S NAME AND ADDRESS:*** _____

____I HAVE SYMPTOMS RELATED TO COVID-19 AND I AM SEEKING A MEDICAL DIAGNOSIS.

____I AM CARING FOR AN INDIVIDUAL WHO IS SUBJECT TO A FEDERAL, STATE OR LOCAL QUARANTINE OR ISOLATION ORDER OR HAS BEEN ADVISED BY A HEALTH CARE PROVIDER TO SELF-QUARANTINE RELATED TO COVID-19. ***RELATIONSHIP TO INDIVIDUAL:*** _____ ***HEALTH CARE PROVIDER'S NAME AND ADDRESS:*** _____

____I AM CARING FOR AN INDIVIDUAL WHO IS PARTICULARLY VULNERABLE TO COVID-19 AND WAS ADVISED BY A HEALTH CARE PROVIDER TO SELF-QUARANTINE RELATED TO COVID-19. ***RELATIONSHIP TO INDIVIDUAL:*** _____ ***HEALTH CARE PROVIDER'S NAME AND ADDRESS:***

_____

____I NEED TO CARE FOR MY CHILD UNDER AGE 18 BECAUSE THE CHILD'S SCHOOL, CHILD CARE OR CHILD CARE PROVIDER IS CLOSED OR UNAVAILABLE BECAUSE OF COVID-19. FOR CHILDREN OVER THE AGE OF 14, A STATEMENT INDICATING THE SPECIAL CIRCUMSTANCES THAT REQUIRE THE EMPLOYEE TO PROVIDE CARE DURING DAYLIGHT HOURS MUST BE INCLUDED.

NAME OF MINOR CHILD(REN) AND NAME(S) AND ADDRESS(ES) OF MINOR CHILD(REN)'S SCHOOL, CHILD CARE OR CHILD CARE PROVIDER(S):

MINOR CHILDREN: _____

_____

SCHOOL AND/OR CHILD CARE PROVIDER(S): _____

_____

____I AM EXPERIENCING ANY OTHER SUBSTANTIALLY SIMILAR CONDITION SPECIFIED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES.

PROVIDE ANY SUPPORTING DOCUMENTATION RELATED TO YOUR NEED FOR EPL. FOR EXAMPLE, PLEASE PROVIDE ANY QUARANTINE ORDERS, DIRECTIVES FROM A HEALTH CARE PROVIDER ADVISING YOU OR AN INDIVIDUAL TO WHOM YOU ARE PROVIDING CARE TO SELF-QUARANTINE, OR COMMUNICATIONS FROM A SCHOOL OR CHILD CARE FACILITY NOTIFYING YOU OF ITS CLOSURE.

I WILL NEED (CHOOSE ONE): CONTINUOUS LEAVE: ___ INTERMITTENT LEAVE: ____

IF YOUR NEED FOR LEAVE IS INTERMITTENT, PLEASE DESCRIBE THE NATURE OF YOUR INTERMITTENT LEAVE:

_____

IF TELEWORKING, INTERMITTENT LEAVE IS NOT GUARANTEED AND WILL BE EVALUATED BASED UPON BUSINESS NEEDS.

BRIEF STATEMENT OF SPECIAL CIRCUMSTANCES REQUIRING ME TO CARE FOR MY CHILD(REN) OVER THE AGE OF 14 DURING DAYLIGHT HOURS:

_____

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE AND COMPLETE. I UNDERSTAND THAT IF THE CIRCUMSTANCES OF MY LEAVE CHANGE, AND I AM ABLE TO RETURN TO WORK EARLIER THAN THE DATE INDICATED ON THIS FORM, I AM REQUIRED TO NOTIFY MY EMPLOYER.

EMPLOYEE SIGNATURE:_____ **DATE:** _____

FOR HUMAN RESOURCES' INTERNAL USE ONLY: RECEIVED BY: _____ DATE: _____

Revised: 4/13/2020