

Emergency Sick Leave Request Form

EMPLOYEE: You must complete this form and submit it to your employer when requesting paid sick leave under the **Emergency Paid Sick Leave Act (EPSLA)**. If you are unable to complete the form, you must provide the information orally. The information you provide orally will be noted; however, you must still complete this form when reasonably possible. **You may be required to provide additional written support for the reason you request leave. If such required written support is not provided, your leave may be denied.**

Employee Information

Employee Name (Please print) _____ Date _____

Leave Beginning Date _____ Leave End Date _____

Emergency Sick Leave Request (Check the applicable qualifying reason and complete the required information)

- ☐ 1. I am subject to a federal, state, or local **quarantine or isolation order** related to COVID-19. This quarantine or isolation order is specific to me **OR** I am a member of a group of citizens for whom this order specifically applies.

Name of the governmental entity issuing the quarantine or stay-at-home order: _____

- ☐ 2. I have been directed or advised by a **health care provider** to self-quarantine due to concerns related to COVID-19.

Name of the health care provider directing or advising self-quarantine: _____

- ☐ 3. I am experiencing **symptoms of COVID-19** and am seeking a medical diagnosis. (Symptoms include fever, dry cough, shortness of breath or other COVID-19 symptoms identified by the CDC. Employee must be seeking a medical diagnosis for this option to apply. Time spent making, waiting for, or attending an appointment for a COVID-19 test is covered.)

Please describe the actions you have taken to seek a medical diagnosis: _____

- ☐ 4. I am **caring for an individual** who is subject to an order as described under Reason #1 above or who has been directed or advised as described under Reason #2 above. (The individual in need of care must be someone with whom the employee has a personal relationship, including an immediate family member, a person who regularly resides in the employee's home, a roommate, or a similar person with whom the employee has a relationship that creates an expectation that the employee would care for the person if he or she self-quarantined or was quarantined.)

Name of the individual you will care for: _____

Relationship of this person to you: _____

Initial the following statements that apply to your situation. If neither applies, do not initial either:

_____ This person genuinely needs and depends on my care; he or she is unable to care for himself or herself.

_____ Although the person is not a family member or someone who resides in my home, my relationship with him or her creates an expectation that I would care for the person if he or she was quarantined or self-quarantined.

Select one of the following and provide the corresponding required information:

- ☐ Person is subject to a government-issued quarantine or isolation order.

OR

- ☐ Person has been directed or advised to self-quarantine by a health care provider due to concerns related to COVID-19.

Name of the **governmental entity** issuing the quarantine or stay-at-home order **OR** name of the **health care provider** advising self-quarantine: _____

CONTINUED ON BACKSIDE

EMPLOYER: This form is for employees who request emergency paid sick leave under the **Emergency Paid Sick Leave Act (EPSLA)** between April 1, 2020, and December 31, 2020. Up to 80 hours of paid sick leave over a two-week period are available to full-time employees with qualifying circumstances. Part-time employees are eligible for a prorated amount of paid sick leave, calculated according to the regulations. Reasons #1-3 above are paid at the employee's regular rate. Reasons #4-5 are paid at 2/3 the employee's regular rate. If an employee cannot complete the form at the onset of the leave, obtain the information orally from the employee and document it on this form. The employee can then sign the form when reasonably possible. The original leave request form and accompanying documentation must be maintained for a period of four years. **Employees who are able to work remotely do not qualify for emergency paid sick leave while they are working.**

- ☐ 5. I am caring for my **son or daughter** whose school or place of care has closed, or whose child care provider is unavailable, due to COVID-19 precautions. *(A child care provider is a provider who receives compensation for providing child care services on a regular basis, including nannies, au pairs, and babysitters, except that family members, friends, and neighbors who regularly care for the child need not be compensated. A place of care includes daycare facilities, preschools, before- and after-school-care programs, schools, homes, summer camps, summer enrichment programs, and respite care programs.)*

IF YOU ARE CARING FOR MORE THAN ONE SON OR DAUGHTER, COPY THIS PAGE AND COMPLETE ONE PAGE PER CHILD.

Name of son or daughter: _____

Age of the child: _____

If your child is over 18, is he or she incapable of self-care because of a mental or physical disability? ☐ YES ☐ NO

If your son or daughter is over 14 and you are taking emergency paid sick leave to care for him or her during daylight hours, provide a statement that special circumstances exist that require you to provide care:

Select which situation applies and provide the corresponding required information:

- ☐ School or place of care has closed due to COVID-19 precautions.

Name of the school **or** place of care that closed: _____

OR

- ☐ Child care provider who provides child care services on a regular basis is unavailable due to COVID-19 precautions.

Name and position of the child care provider who is unavailable: _____

If requested, you must provide a notice of closure or unavailability from your child's school, place of care, or child care provider, including a notice that may have been posted on a government, school, or daycare website, published in a newspaper, or emailed to you from an employee or official of the school, place of care, or child care provider.

Employee attestation for leave taken to care for a son or daughter: *(Employee must read and, if true, sign)*

I attest that no other suitable person will be providing care for my son or daughter who is named above for the period of time I have requested emergency paid sick leave.

Employee Signature _____ **Date** _____

Employee Attestation

I attest that I am requesting emergency paid sick leave for the reason I have indicated above and that I am unable to work or telework because of this reason. If required, I agree to provide additional written support for the sick leave reason I have indicated.

Employee Signature _____ **Date** _____

Management Approval

Select one:

- ☐ I have reviewed the above request for emergency paid sick leave and determined that the employee is eligible for the leave. The hours of emergency paid sick time used and qualified wages eligible for the tax credit will be documented in the payroll records.
- ☐ I have reviewed the above request for emergency paid sick leave and determined the employee is NOT eligible for the leave for the following reason: _____

Manager Signature _____ **Date** _____