**EMPLOYEE REQUEST FOR**

**EMERGENCY PAID SICK LEAVE**

**EMERGENCY FAMILY AND MEDICAL LEAVE**

Employees requesting Emergency Paid Sick Leave (EPSL) and/or Emergency FMLA (EFMLA) 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 it to Human Resources for processing.

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| Employee Name:      |
| Employee Home Address:      E-mail:      |
| Home Phone Number:      Cell Phone Number:      |
| **This is an** *(choose one)***:** [ ]  Emergency Paid Sick Leave (EPSL) [ ]  Emergency FMLA (EFMLA to care for child due school closure or childcare provider unavailable) |
| Anticipated Begin Date of Leave:       Expected Return to Work Date:       |
| **Reason for Leave** (*check all applicable*) I am unable to work (or telework) for the following reasons: [ ]  I’m currently subject to federal, state or local quarantine or isolation order related to COVID-19.  Name of Government Entity:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  I’ve been advised by a healthcare provider to self-quarantine related to COVID-19. Name of Healthcare Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  I’m experiencing COVID-19 symptoms and seeking a medical diagnosis. Name of Healthcare Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  I’m caring for an individual subject to a quarantine or isolation order related to COVID-19. Name of Individual/Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Healthcare Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  I’m caring for a child whose school or place of care is closed due to COVID-19. Name/Age of Child:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of School/Place of Care/Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ I certify that there is no other suitable person to care for my child: [ ]  Yes [ ] No If child is older than 14, please provide statement of special circumstances:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  I’m experiencing other substantially similar condition specified by the U.S. Department of Health and Human Service. |
| **I will need** *(choose one)***:** [ ]  Continuous leave [ ]  Intermittent leaveIf your need for leave is intermittent, please describe the nature of your intermittent leave: |
| **Substitution of Paid Leave:**  Pursuant to the FFCRA, the first 10 days of your leave is unpaid, however you may be eligible for emergency sick leave provided through the FFCRA. In the event you are not eligible for emergency sick leave, you are permitted to use available paid leave to cover this period. Please indicate if you would like to use paid leave during the first 10 days of your absence (if you are not eligible for emergency sick leave) and how many hours you plan to use. [ ]  Vacation (      Hrs) [ ]  Sick Leave (      Hrs)  |

I certify that the above information is accurate and complete. I understand that if I fail to report for work on or before the scheduled return date indicated above or fail to contact Human Resources regarding my absence from work beyond such scheduled date of return, my employer may take corrective action.

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supervisor Signature**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Human Resources**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_