EMERGENCY PAID SICK LEAVE REQUEST

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 it to _____for review, approval and processing.

Employee Name:
Employee Home Address: **E-mail:**
Home Phone Number: **Cell Phone Number:**
Anticipated Start Date of Leave: **Expected End Date of Leave:** **(Maximum EPSL for full-time employees is 80 hours. Part-time employees 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.** ☐ **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.** ☐ **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.** **Name of minor child(ren) and name(s) and address(es) of minor child(ren)'s school, child care 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.**

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: _____