



REQUEST FOR EMERGENCY PAID SICK LEAVE

To request emergency paid sick leave as provided under the Families First Coronavirus Response Act (FFCRA), please complete the following request form and submit to your manager or _____ as soon as possible before leave commences. Verbal notice will be accepted until a form can be provided.

Supporting documentation and/or information for the need for leave must be included as applicable with this request as set forth in the attached pages.

Employee Name (print clearly): _____

Department: _____

Manager: _____

Requested Leave Start Date: _____ End Date: _____

The amount of emergency paid sick leave being requested is _____ hours.

I am requesting this emergency paid sick leave due to my inability to work (or telework) because (check the appropriate reason below):

- 1) I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.
- 2) I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
- 3) I am experiencing symptoms of COVID-19 and seeking a medical diagnosis.
- 4) I am caring for an individual who is subject to either number 1 or 2 above.
- 5) I am caring for my child whose primary or secondary school or place of care has been closed, or my childcare provider is unavailable due to COVID-19 precautions; and,
- 6) I am experiencing another substantially similar condition specified by the U.S. Department of Health and Human Services.

I have completed and included information and/or documentation supporting my need for leave as applicable.

Employee Signature: _____ Date: _____

Manager Signature: _____ Date: _____

HR Rep. Signature: _____

Date: _____



To be considered eligible for emergency paid sick leave for the qualifying reason of a quarantine order or self-quarantine advice from a health care provider, an employee must provide the following information:

Name, phone number, and address of the health care professional advising self-quarantine OR name of the governmental entity ordering quarantine

Name of clinic/hospital/telemed service

Date of service

Full name of individual subject to a quarantine order or advised to self-quarantine by a health care provider (*if other than employee*)

Relationship to employee

Employee Attestation:

I understand that providing false or misleading information regarding the need for emergency paid sick leave or any FFCRA qualifying event will be grounds for corrective action, up to and including termination of employment.

Employee Signature: _____

Date: _____



To be considered eligible for emergency paid sick leave and/or expanded family and medical leave for the qualifying reason of a child's school or childcare provider closure or unavailability due to COVID-19 related reasons, an employee must provide the following information:

Name, address, phone number of school or place of care that is unavailable

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Full name and age of child to be cared for

Full name and age of child to be cared for

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Full name and age of child to be cared for

Full name and age of child to be cared for

For any child older than 14, provide a statement detailing the special circumstances that exist requiring you to provide care during daylight hours thus rendering you unable to work or telework.

Employee Attestation:

I certify that no other suitable person is available to care for the child(ren) named above during the period for which I am receiving emergency paid sick leave and/or expanded family and medical leave.

I have attached documentation supporting the notice of closure or unavailability from the school, place of care, or child care provider for the child(ren) named above.

I understand that providing false or misleading information regarding the need for emergency paid sick leave and/or expanded family and medical leave or any FFCRA qualifying event will be grounds for corrective action, up to and including termination of employment.

Employee Signature: _____

Date: _____