

**EMERGENCY PAID SICK LEAVE REQUEST FORM
FOR COVID-19-RELATED LEAVE**

Effective for requests made on or after April 1, 2020 through December 31, 2020.

The Families First Coronavirus Response Act (ACT), enacted on March 18, 2020, provides employees with access to Emergency Paid Sick Leave (EPSL) for certain leave requests related to the COVID-19 pandemic. As of April 1, 2020, EPSL is available for immediate use by qualifying employees. Full-time employees are eligible for up to 80 hours of EPSL. Part-time employees are eligible for EPSL in an amount equal to the number of hours the employee works, on average, over a two-week period. All paid leave under the Act is subject to the caps outlined further below. Employees should contact their supervisors with any questions.

I am unable to work or telework and would like to request Emergency Paid Sick Leave for the following reason(s) (check all that apply and supply the indicated documentation):

EMPLOYEE EPSL REQUEST:

Date: _____ Employee ID: _____

Name (please print): _____

Employee Title/Position: _____ Department: _____

Employee Supervisor: _____

Dates of Leave Requested: _____

I would like to request EPSL for the following reason(s) (check all that apply):

1. I am unable to work due to a Federal, State, or local quarantine or isolation order prohibiting me from working due to COVID-19. **(name of government entity that issued the quarantine or isolation order _____)**
2. I am unable to work because a health care provider has advised me to self-quarantine due to concerns related to COVID-19. **(name of health care provider who advised employee to self-quarantine _____)**
3. I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis. **(name of health care provider or government entity providing care _____)**

If neither 1, 2, nor 3 above apply, I am requesting EPSL for the following, alternative reason(s) (check all that apply):

4. I am unable to work because I am caring for an individual who is subject to a Federal, State, or local quarantine or isolation order under paragraph (1) or who has been advised by a health care provider to self-quarantine describe in paragraph (2). **(Name and relationship of individual you are caring for and provide indicated documentation in (1) and/or (2) as appropriate _____)**

5. ___ I am unable to work because I am caring for my son or daughter whose school or place of care has been closed or whose childcare provider is unavailable due to COVID-19 precautions.

•The name/age of the child(ren) being cared for: _____

•The name of the school, place of care, or childcare provider that has closed or become unavailable: _____

•Please initial: ___ NO other suitable person is available to care for the child(ren) during the periods I am requesting leave.

6. ___ I am unable to work because I am experiencing other substantially similar conditions as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.

I understand I will be compensated at 2/3 of my regular rate of pay for reasons (4), (5), and (6) unless I choose to supplement it with my sick or vacation leave.

Do you wish to supplement your pay with sick or vacation leave? Y / N

If so, please indicate the order in which you prefer to use your leave:

Sick _____

Vacation _____

Compensation for EPSL may vary depending on the basis of the employee's request, and it is subject to certain caps. The determination of compensation is outlined in the State's policy. If necessary, the State may request additional information or documentation regarding the employee's EPSL request.

Employee Signature: _____ Date: _____

Human Resource Manager Signature _____ Date: _____