Employee Request for Emergency Paid Sick Leave

Employees requesting Emergency Paid Sick Leave (EPSL) provided within the Families First Coronavirus Response Act (FFCRA) must complete this form. You must provide as much advance notice as is reasonably practical. Submit your completed form to Human Resources for processing.

EMPLOYEE NAME (LAST, FIRST, MI)	HOME EMAIL (OPTIONAL)
PRIMARY PHONE NUMBER	**SECONDARY PHONE NUMBER (OPTIONAL)**
ANTICIPATED LEAVE START DATE	**EXPECTED RETURN TO WORK DATE**
THIS IS A (CHOOSE ONE)	**I AM REQUESTING (CHOOSE ONE)**
☐ New request for leave ☐ Request for extension of existing leave	☐ Continuous leave ☐ Intermittent leave

IF INTERMITTENT, PLEASE DESCRIBE EXPECTED DATES AND TIMES OF YOUR LEAVE

I AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASONS (CHECK ALL THAT APPLY):

- ☐ I am subject to a federal, state or local quarantine or isolation order related to COVID-19 (complete below).
- ☐ I have been advised by a health care provider to self-quarantine related to COVID-19 (complete below).
- ☐ I am experiencing COVID-19 symptoms and seeking a medical diagnosis (complete below).
- ☐ I am caring for an individual who is subject to a federal, state or local quarantine or isolation order related to COVID-19 or has been advised by a health care provider to self-quarantine related to COVID-19 (complete below).
- ☐ I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.
- ☐ I need to care for my child(ren) under age 14 because their school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19 (complete below).
- ☐ I am seeking or awaiting the results of a COVID-19 diagnostic test or medical diagnosis.
- ☐ I am obtaining a COVID-19 immunization during my regularly scheduled work hours.
- ☐ I am recovering from an injury, disability, illness or condition related to the COVID-19 immunization I received.

PERSON SUBJECT TO QUARANTINE / SELF-QUARANTINE	RELATIONSHIP TO EMPLOYEE	GOVERNMENTAL ENTITY OR HEALTH CARE PROFESSIONAL ADVISING QUARANTINE

CHILD(REN) NAME(S) / AGE(S)	NAME OF SCHOOL / CARE PROVIDER

I certify that the above information is accurate and complete. I also certify that I am unable to work or telework for the above indicated reasons and that no suitable person is available to care for my child(ren) during daylight hours for the period I am requesting emergency paid sick leave. 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.

Please note that IRS and DOL documentation requirements could change requiring submittal of additional information.

Employee Signature: _____ **Date:** _____

Human Resources Signature: _____ **Date:** _____