

EMERGENCY PAID SICK LEAVE REQUEST

Employees requesting 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 Human Resources for processing.

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|---|--------------------------------------|
| Employer: | |
| Employee Name: | E-mail: |
| Employee Home Address: | |
| Home Phone Number: | Cell Phone Number: |
| This is a (choose one): <input type="checkbox"/> New request for leave <input type="checkbox"/> Request for an extension of leave | |
| Anticipated Begin Date of Leave: | Expected Return to Work Date: |
| <p>Reason for Leave (check all applicable) I am unable to work (or telework) for the following reasons:</p> <p><input type="checkbox"/> I am subject to state, federal or local quarantine or isolation order related to COVID-19. (PSL1) Government entity that issued order:</p> <p><input type="checkbox"/> I have been advised by a health care professional to self-quarantine due to concerns related to COVID-19. (PSL1) Name and contact information for provider who advised self-quarantine:</p> <p><input type="checkbox"/> I have symptoms related to COVID-19 and I am seeking a diagnosis. (PSL1)</p> <p><input type="checkbox"/> I am caring for an individual who is subject to quarantine or has been advised to quarantine related to COVID-19. (PSL2) Name of individual caring for: Relationship to employee: Government entity that issued order: Name and contact information for provider who advised self-quarantine:</p> <p><input type="checkbox"/> 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 and no other suitable person is available to care for the child during the period of leave requested. (PSL 2) Name and age of child(ren): Name and address of school, place of care, or provider: If child(ren) is over age 14, you must include a statement indicating the special circumstances that require you to provide care during daylight hours:</p> <p><input type="checkbox"/> I am experiencing other conditions substantially similar to COVID-19 as specified by HHS. (PSL2) I will need (choose one): <input type="checkbox"/> Continuous leave <input type="checkbox"/> Intermittent leave If your need for leave is intermittent, please describe the nature of your intermittent leave:</p> | |

I certify that the above information is accurate and complete. I understand that providing false or misleading information regarding the need for EPSL or any FFCRA qualifying event will be grounds for corrective action, up to and including termination of employment. 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:** _____

Employer Signature: _____ **Date:** _____