COVID-19: Request for Emergency Paid Sick Leave

Request for Emergency Paid Sick Leave

The Families First Coronavirus Response Act (FFCRA) requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020. In general, employees are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons. A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

Please complete the following form if you are requesting to take Emergency Paid Sick Leave (EPSL) under the Families First Coronavirus Response Act (FFCRA). The information requested in this form must be submitted as soon as practicable after the need for leave arises.

Employee Name: _____

Date of Request: _____

SECTION 1 (required)

I am requesting EPSL because I am unable to work or telework because of the following reason:

_____ I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

The government agency that has issued the quarantine or isolation order is: _____ (e.g. state, county, city).

_____ I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

The name of the health care provider who has advised me to self-quarantine due to concerns related to COVID-19 is:
_____.

_____ I am experiencing symptoms of COVID-19 and seeking a medical diagnosis.

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_____ I am caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

The government agency that has issued the quarantine or isolation order is _____ (e.g. state, county, city).

The name of the health care provider who has advised the individual to self-quarantine who I am caring for is_____.

NOTE: A qualifying "individual" for whom an employee is caring for is defined under the FFCRA protocol.

_____ I am caring for a son or daughter whose school or place of care has been closed, or whose child care provider is unavailable, due to COVID-19 precautions.

The name of my son or daughter whom I am caring for is _____.

The name of my son or daughter's school, place of care, or child care provider that is closed or unavailable is _____.

I hereby represent that there is no other suitable person to car for my son or daughter during the period in which I am requesting EPSL.

_____
Employee Signature

_____ I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

SECTION 2 (required)

I am requesting EPSL begin on _____, 2020.

I expect to use EPSL until _____, 2020.

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SECTION 2A (optional)

I am requesting to take EPSL on an intermittent basis: _____ Yes _____ No

I am requesting to take EPSL on an intermittent basis as follows:

_____.

I am requesting to take EPSL on an intermittent basis for the following reason(s):

_____

_____.

Taken intermittently as follows: non-telecommuting employees may only take EPSL intermittently if they are requesting the leave to care for a son or daughter whose school or place of care has been closed or the childcare provider of the son or daughter is unavailable. Telecommuting employees may take EPSL intermittently for any qualifying reason. I acknowledge that my request to take EPSL intermittently may be denied if it is not for these reasons.

_____
Employee Signature

SECTION 3 (required)

I certify that the above information is true and correct.

_____ _____
Employee Signature Date

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FOR HUMAN RESOURCES USE:

THIS COMPLETED FORM AND ANY OTHER DOCUMENTATION RELATED TO THE REQUEST FOR EFMLA OR EPSL MUST BE RETAINED FOR 4 YEARS REGARDLESS OF WHETHER LEAVE IS GRANTED OR DENIED.

Date: _____

Request for EPSL Approved: _____ Yes _____ No

Dates of Approved EPSL: _____ _____

NOTES:

_____

_____

_____

_____

APPROVED BY:

_____
Area Vice President: Name and Title

_____
Area Vice President: Signature

_____
Vice President, Human Resources: Name

_____
Vice President, Human Resources: Signature