



REQUEST FOR EMERGENCY SICK LEAVE

To be completed by the employee requesting Emergency Paid Sick Leave arising out of an eligible reason related to COVID-19.

_____ Time off during a specific period of time.
Requested Leave Start Date: _____
Estimated Return Date: _____

_____ Intermittent use, such as augmenting worked hours.

(Maximum leave duration of EPSL is 80 hours for full-time employees and a pro-rata amount for part-time employees; for emergency FMLA leave arising out of childcare obligations, employees must also complete a Request for FMLA Expansion Leave)

I, _____, certify that I am unable to work (or telework) for one of the following reasons:

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

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

_____ I am experiencing symptoms of COVID-19 (*e.g.*, fever [defined as 100.4° F [37.8° C] or greater using an oral thermometer], coughing, and/or shortness of breath) and seeking a medical diagnosis.

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

Relationship to individual: _____

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

_____ I am experiencing another 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.

During my leave, I can be reached at:

Email Address

Telephone Number

I understand that I will be required to provide timely medical or other certification as a condition of obtaining Emergency Paid Sick Leave, unless the certification cannot be practicably be obtained. I understand that it is my obligation to discuss any inability to obtain the requested certification with Human Resources.

Employee Signature/Acknowledgement:

By submitting this request for Emergency Paid Sick Leave, I certify that: all information provided in this request is true and accurate and that I am eligible for paid leave for the reasons stated; I will update my supervisor and Human Resources if my availability for work changes or if my ability to work or telework changes; I understand that if my circumstances change and any of the above cease to apply to me, I must immediately inform my supervisor of that change.

Signature

Date

Human Resources

Date