**EMERGENCY PAID SICK LEAVE FORM**

Employees requesting Emergency Paid Sick Leave (EPSL) pursuant to the Families First Coronavirus Response Act (FFCRA) must complete this form. If you are requesting sick leave due to unavailability of childcare related to COVID-19, you must fill out the form related to childcare leave. 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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| **PART I: TO BE COMPLETED BY HUMAN RESOURCES** | | |
| **1.** Employee Name: SSN or Employee No.: | | **2.** Date of Hire: |
| **3.** Employee Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| **PART II: TO BE COMPLETED BY EMPLOYEE – PLEASE PRINT OR TYPE** | | |
| **4.** Please provide the reason(s) you are requesting leave (check appropriate box and provide the information requested): | | |
| 🞎 (1) Because I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19  **Name of the government entity that issued the quarantine or isolation order**:  🞎  (2) Because I have been advised by a healthcare provider to self-quarantine for reasons related to COVID-19  **Name of the health care provider who advised you to self-quarantine:**  🞎  (3) Because I am experiencing COVID-19 symptoms and am seeking a medical diagnosis. **Please provide a doctor's note as soon as practicable. You will also be required to provide a return to work certification from your doctor before you can return to work.** | 🞎 (4) To care for an individual subject to quarantine (pursuant to federal, state, or local government order or advice of a health care provider) or has been advised by a healthcare provider to self-quarantine related to COVID-19. Please provide the following information:  **Relationship to the individual**:  **Government entity that issued the quarantine or isolation order to which the individual is subject**:    **Name of the health care provider who advised the individual to self-quarantine**:    🞎  (5) Because I am experiencing any other substantially similar condition specified by the U.S. Department of Health and Human Services.  **Explain**: | |
| **5.** I request leave from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Employee Representation:** I hereby represent that I am unable to 🞎 Work and/or 🞎 Telework because:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employee Signature Date | | |
| **6.** Are you requesting Emergency Paid Sick leave on an intermittent or reduced leave schedule? (*NOTE: intermittent leave is not permitted if you are not working remotely*)  🞎 Yes 🞎 No | | **7.** If the answer to **"6"** is **"Yes,"** please describe the proposed intermittent/reduced work leave schedule: |
| **Limitations on Pay:***Emergency paid sick leave is available for up to 80 hours for a full-time employee or, for a part-time employee, the average number of hours worked over a typical two-week period. If approved, emergency sick leave for reasons (1)-(3) above will be for a maximum of $511 per day, or $5,110 total over the entire paid sick leave period. If approved, emergency sick leave for reasons (4) and (5) above will be paid at 2/3 of your normal pay, for a maximum of $200 per day, or $2,000 over the entire two-week period.*  **Supplemental Paid Leave:** *If you are requesting leave for reasons (4) and (5) above, you may also elect to use any accrued and unused paid leave benefits under the Company's policies to supplement the 2/3 pay, up to your full normal pay. Please indicate if you would like to use any available accrued benefits:*  🞎  Sick Leave 🞎 Vacation/PTO | | |
| **I have read and understand this form and certify that the information provided on this form is true, correct, and complete. I understand that additional documentation will be required prior to making a final determination to approve or deny my leave request.**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **EMPLOYEE SIGNATURE DATE** | | |

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| **FOR INTERNAL USE ONLY**  EPSL Leave is: 🞎 **APPROVED** from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  🞎 **DENIED** because:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_      Intermittent/Reduced Schedule Leave? 🞎 Yes 🞎 No Anticipated Schedule: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Continue voluntary benefits coverage? 🞎 Yes 🞎 No Premium amount:: $\_\_\_\_\_\_\_\_  Premiums paid by: Payroll Deduction:  Other:    Amount of accrued paid time off remaining or anticipated to be available at the time leave commences: \_\_\_\_\_\_\_\_\_ Days |
| **REQUEST APPROVED/DENIED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |