

Employee Request for Emergency Paid Sick Leave

Name of Employee:	Job Position:	Job Location:

A. INSTRUCTIONS TO EMPLOYEE

The federal “Emergency Paid Sick Leave Act” (EPSLA) (a part of the new “Family First Coronavirus Response Act”) provides employees up to 80 hours of emergency paid sick leave (EPSL) for specified Coronavirus (COVID-19) related reasons (listed in section B below). If you believe you qualify for EPSL, please complete sections B, D, and F of this form and submit it to Human Resources (HR) (submission instructions are below). Be as specific as you can. While you are not required to provide the information requested, your failure to do so may result in denial of your request. For some requests, you may be required to submit medical or other appropriate documentation.

B. QUALIFYING REASONS FOR EPSL and SUPPORTING DOCUMENTATION / INFORMATION

The chart below lists *six* qualifying reasons for EPSL. To qualify for EPSL, you must certify that you are unable to come to work or to work from home (telecommute) due to one of these reasons. Please circle (in the first column) the reason you qualify for EPSL. The third column lists documentation you must provide to support your request. If documentation is unavailable, you may provide the information requested and certify that such information is true and accurate by your signature at the end of this form. For medical documentation, please review the clarification at the end of this form.

Select	Covered Reason for EPSL (i.e., the reason why you are not able to come to work or work at home)	Documentation or Certification Required
1	I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.	Documentation of order is attached: <input type="checkbox"/> Yes <input type="checkbox"/> No If not available, identify relevant Order received: _____ _____.
2	I have been advised by a health care provider (HCP) to self-quarantine due to concerns related to COVID-19.	Medical documentation of advisement is attached: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If not available</i> , provide name and contact info of advising HCP: _____ _____. Date of advisement by HCP: _____.
3	I am experiencing symptoms of COVID-19, and I am in the process of seeking a medical diagnosis.	Medical documentation of my diagnosis, or my efforts to obtain a diagnosis, is attached: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Or</i> , provide name and contact info of HCP contacted: _____ _____. Date of contact with HCP: _____.
4	I am caring for an individual subject to an order as described in Reason # 1, or who has been advised by an HCP to self-quarantine due to concerns related to COVID-19.	Name of individual and relationship to employee: _____ _____. Documentation of order is attached: <input type="checkbox"/> Yes <input type="checkbox"/> No If not available, identify relevant Order received: _____ _____. <i>Or -</i> Medical documentation of advisement is attached: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Or</i> , provide name and contact info of advising HCP: _____ _____. Date of advisement by HCP: _____.

5	I am caring for my child(ren) because their school or place of care has been closed, or their childcare provider is unavailable, due to COVID-19 precautions.	Documentation of closure notification is attached: <input type="checkbox"/> Yes <input type="checkbox"/> No Name and age of child(ren): _____ Name and contact info of school/childcare center: _____ <i>By signing below, I certify that, as a result of the closure, I must care for my child(ren), and no other suitable person is available to care for my child(ren) during the period in which I would be receiving leave. My spouse is not receiving EPSL at the same time as me.</i> <i>I certify that, for any child(ren) over the age of 14, the following special circumstances require me to care for my child(ren) during the day: ___</i> _____
6	I am experiencing another substantially similar condition specified by Sec. Health & Human Services [#6 is pending further guidance by U.S. DOL, expected in near future].	Documentation supporting Reason #6 is attached: <input type="checkbox"/> Yes <input type="checkbox"/> No <i>[Note: Reason #6 is pending further guidance from U.S. DOL]</i>

C. EXPLANATION OF BENEFITS AVAILABLE

Full-time employees are eligible for up to 80 hours of EPSL. Part-time employees may receive up to 2 weeks, based on the prior 2-week average. Rate of pay during EPSL depends on the reason for the leave, and certain caps apply.

- For EPSL per Reasons 1-3, you will receive full current pay (wages or salary, as applicable), capped at \$510.00 per day, up to a maximum of \$5,110 for the full leave period.
- For EPSL per Reasons 4-6, you will receive two-thirds (2/3) of your current pay (wages or salary), capped at \$200 per day, up to a maximum of \$2,000 for the full leave period.

D. AMOUNT OF LEAVE REQUESTED

EPSL is intended to be used for a consecutive period (e.g., 2 consecutive weeks, up to 80 hours). In limited circumstances (when (i) an employee is experiencing Reasons 1-4, but is able to work intermittently from home; or (ii) an employee is experiencing Reason 5, and is able to work intermittently at home or in the workplace) EPSL may be used intermittently on certain days (up to the maximum hours permitted). You may use EPSL only in full day (8-hour) increments.

What is your requested start date?	
How many hours are requested? (Up to 80 hours for FT employees.)	
If intermittent days are requested, list dates (if known at this time) of all days that you request for intermittent EPSL.	

E. HOW TO SUBMIT THIS FORM

Please sign and submit this form to HR by (1) hand delivery, or (2) email. If submitting by email, attach as a PDF. If you cannot create a PDF, attach a *legible* photograph of the form, taken on a smart phone.

F. CERTIFICATION BY EMPLOYEE

I certify that the information I provided above is true and correct, and that any documentation I submitted is true and correct. I certify that because of the Covered Reason selected in Section B, I am unable to work, including by telework, for such reason. I understand that my failure to provide truthful information on this form, or my usage of Emergency Paid Sick Leave for any purpose other than those describe above, may result in disciplinary action, including termination.

Signature: _____ **Date:** _____

G. OTHER IMPORTANT INFORMATION

MEDICAL DOCUMENTATION: If you submit medical documents in support of your request, it should be signed by a licensed HCP and state that you qualify under one of the designated reasons for EPSL. Such documentation need not include any explanation about a particular illness, injury, or other medical condition. You do not need to provide personal medical information. Moreover, recognizing the difficulty of obtaining medical documentation in the current environment, the alternative information requested may be sufficient to support your request.

RETALIATION PROHIBITED: The company will not take adverse action against you for requesting EPSL, using EPSL, or attempting to exercise a right under EPSLA. If you believe you are being retaliated against for these reasons, notify Human Resources immediately.

OTHER LEAVE: The Company will not require you to use any other type of paid leave prior to using EPSL.

LAYOFFS, FURLOUGHS, REDUCED WORK HOURS: EPSL is not available if you have been laid off, furloughed, or subject to reduced hours, whether such event occurred before or after the effective date (Apr. 1). You may, however, qualify for unemployment compensation.

EXPIRATION: EPSL is available starting on April 1, 2020. The Act expires on December 31, 2020. You will not be entitled to cash out unused EPSL at the end of 2020 or upon separation from employment.