EMERGENCY PAID SICK LEAVE NOTICE

Employees who are unable to work (or telework) for a reason that qualifies for 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_____ for review, approval and processing.

Employee Name:	
Home Address:	**E-mail:**
Home Phone Number:	**Cell Phone Number:**
Anticipated Start Date of Leave:	**Expected End Date of Leave:**

(Maximum EPSL for full-time employees is 80 hours. Part-time employees are entitled to a maximum amount of EPSL equal to their average work hours over a two week period.)

By signing below, I certify that I am unable to work (or telework) for the following reason(s) *(check all applicable)*:

☐ **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 have symptoms related to COVID-19 and I am seeking a medical diagnosis.**

☐ **I am caring for an immediate family member, a person who regularly resides in my home, or a person with whom I have a relationship that creates an expectation that I provide care for that person if that person were quarantined and that person is subject to a federal, state or local quarantine or isolation order or has been advised by a health care provider to self-quarantine related to COVID-19.**

Provide the name of the governmental entity ordering quarantine or isolation, the name of the health care provider advising self-quarantine, and, if the person subject to quarantine or advised to self-quarantine is not the employee, that person's name and relation to you.

_____

_____

☐ **I need to care for my son or daughter[1] because his or her school or place of care is closed or child care provider is unavailable because of COVID-19 and no other suitable person is available to care for my son or daughter during the period of requested leave.**

Provide the name of child(ren), age(s), and name(s) and address(es) of child(ren)'s school or place of care or child care provider(s):

_____

_____

☐ **I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services.**

_____

I request *(choose one)*: ☐ **Continuous leave** ☐ **Intermittent leave**

If you are requesting intermittent leave, please describe the nature of leave requested:

_____

IMPORTANT: Intermittent leave is not guaranteed and is subject to the employer's agreement.

I certify that the above information is accurate and complete. I understand that if the circumstances of my leave change, and I am able to return to work earlier than the date indicated on this form, I am required to notify my employer.

Employee Signature:_____ Date:_____

For Human Resources' Internal Use Only:

Received by:_____ Date:_____

[1] "Son" or "daughter" means biological, adopted or foster child, a stepchild, a legal ward or a child of a person standing *in loco parentis*, who is under 18 years of age; or is 18 years of age or older and incapable of self-care because of mental or physical disability.