**EMERGENCY PAID SICK LEAVE REQUEST FORM**

Employees requesting 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 practicable. Upon completion of this form, submit it to **[Insert appropriate individual or department]** for processing.

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| **Employee Name**: |
| **Employee Home Address**:      **E-mail**: |
| **Home Phone Number**:      **Cell Phone Number**: |
| **This is a** *(choose one)***:**  New request for leave  Request for an extension of leave |
| **Anticipated Begin Date of Leave**:       **Expected Return to Work Date**: |
| **Reason for Leave** (*check all applicable*) I am unable to work (or telework) for the following reasons:  I am subject to state, federal 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 related to COVID-19 and I am seeking a medical diagnosis  I am caring for an individual who is subject to quarantine or has been advised to self-quarantine related to COVID-1  I need to care for my child under age 18 because the child’s school, child care or child care provider is closed or unavailable for reasons related to COVID-19  I am experiencing other conditions substantially similar to COVID-19 as specified by HHS. |
| **I will need** *(choose one)***:**  Continuous leave  Intermittent leave  If your need for leave is intermittent, please describe the nature of your intermittent leave:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| If the need for leave is related to a quarantine order, or a recommendation by a health care provider to self-quarantine, please submit the following:   * The name of the governmental entity ordering quarantine:   Or   * The name of the health care professional advising self-quarantine:   If the person subject to the quarantine order or advised to self-quarantine is not you, please state their name and relation to you: |
| If the need for leave is related to a school closing or childcare provider unavailability, please submit the following:   * The name and age of the child (or children) to be cared for: * The name of the school that has closed or place of care that is unavailable:   If the child (or children) is older than fourteen, and you are unable to work or telework because of a need to care for them during daylight hours, please state any special circumstances that exist which require you to provide care.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **By signing this form, I certify that no other person will be providing care for the child (or children) during the period for which I am receiving Emergency Paid Sick Leave.** |

**I certify that the above information is accurate and complete. I understand that if I fail to report for work on or before the scheduled return date indicated above or fail to contact [Insert appropriate individual or department] regarding my absence from work beyond such scheduled date of return, my employer may take corrective action.**

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_