*Employees requesting either EPSL or EFML must complete this form, collect proper documentation supporting the need for leave, and return both to [INSERT COMPANY CONTACT] as soon as practicable. Providing false information or documentation shall constitute a violation of Company policy. If you need more space for any of the answers, please write on a separate piece of paper and attach to this Form.*

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EMERGENCY PAID SICK LEAVE AND UNABLE TO WORK OR TELEWORK**

1. \_\_\_\_\_ I believe I am subject to a federal, state or local quarantine or isolation order related to COVID-19. I attach documentation related to the order.
   1. Name of government entity issuing order:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_ I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. I attach documentation from a health care provider advising self-quarantine.
   1. Name of health care professional: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_ I am experiencing COVID-19 symptoms and seeking a medical diagnosis. I will provide medical documentation from the health care provider when I obtain it.
   1. Name of health care professional from whom seeking diagnosis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. 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. I attach documentation related to the order.
   1. Name of individual to whom providing care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Relationship of person to whom providing care:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Name of government entity issuing order or health care provider advising self-quarantine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. \_\_\_\_\_ I am caring for my son or daughter (S/D) whose school or child-care provider is closed/unavailable due to concerns related to COVID-19. I attach documentation with this request demonstrating that the school or childcare provider is closed/unavailable.
   1. Name and age of S/D:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   2. Name of school or child care provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   3. Will any other person be providing care for the S/D?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
   4. If the S/D is between 14 and 17 years of age, state the special circumstances that exist requiring you to provide care for the S/D during daylight hours:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* 1. If the S/D is 18 years of age or older, state the circumstances that exist requiring you to provide care:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. \_\_\_\_\_ I am experiencing “any other substantially similar condition” specified by the U.S. Department of Health and Human Services.

LENGTH OF LEAVE REQUESTED: Begin: \_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_\_\_\_\_

Have you taken any Emergency Paid Sick Leave previously, even with another employer? Yes \_\_\_\_ or No \_\_\_\_.

1. If the answer is “yes”, provide the name of the employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_

1. If the answer is “yes,” how many hours of Emergency Paid Sick Leave did you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ELECTION TO USE OTHER AVAILABLE LEAVE: *If you qualify for reasons 4, 5, or 6, you will be paid 2/3 of your weekly regular rate of pay for the qualifying period. If you have other accrued, paid time off, you may elect to use your accrued, paid time off to supplement 1/3 of your pay if you qualify for reasons 4, 5, or 6. Please contact [INSERT CONTACT] if you make this election so the process can be explained to you.*

**EMERGENCY FAMILY AND MEDICAL LEAVE (EFML) AND UNABLE TO WORK OR TELEWORK**

\_\_\_\_\_ I am unable to work or telework because I am personally caring for my son or daughter (S/D) because my S/D’s school or childcare provider is closed/unavailable due to the COVID-19 public health emergency. I attach documentation with this request demonstrating that the school or childcare provider is closed/unavailable.

1. Name and age of S/D:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Name of school or child care provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Will any other person be providing care for the S/D?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. If the S/D is between 14 and 17 years of age, state the special circumstances that exist requiring you to provide care for the S/D during daylight hours:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If the S/D is 18 years of age or older, state the circumstances that exist requiring you to provide care:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LENGTH OF LEAVE: Begin: \_\_\_\_\_\_\_\_\_\_\_ End: \_\_\_\_\_\_\_\_\_\_\_\_\_

USE OF OTHER AVAILABLE LEAVE: *The first ten days of EFML will be unpaid. If, however, you qualify for up to 80 hours of EPSL for reasons 1-6, this EPSL can be substituted for the first ten days of unpaid EFML. Or, you may elect to use other accrued, paid time off to cover the first ten days of unpaid EFML. After the first ten days of EFML, and if you have any remaining paid time off available, you will be required to use your remaining paid time off to supplement 1/3 of your pay.*

\_\_\_\_\_ I elect to use other accrued, paid time for the first ten days of unpaid EFML (if applicable).

**BY SIGNING BELOW, I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT ANY FALSE STATEMENT MAY RESULT IN DISCIPLINARY ACTION, INCLUDING TERMINATION OF EMPLOYMENT.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Full Name Signature Date**

**FAILURE TO SUBMIT A COMPLETED FORM WITH SUPPORTING DOCUMENTATION MAY RESULT IN A DELAY IN APPROVING YOUR LEAVE OR A DENIAL OF YOUR REQUEST FOR PAID LEAVE**