

PAID SICK LEAVE REQUEST FORM RELATED TO COVID-19

(FAMILY FIRST CORONA RESPONSE ACT)



Name: _____

Telephone Number: _____

Department: _____

Supervisor: _____

Dates of Sick Leave Needed: _____

The Families First Coronavirus Response Act provides some employees with up to two weeks of Emergency Paid Sick Leave for certain reasons, when an employee is unable to work or telework because of the reason. Please indicate for which reason you are requesting Emergency Paid Sick Leave, *along with the supporting documents requested*:

___ I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19

- If requesting paid sick leave for this reason, you must provide documentation supporting your request that includes:
 1. Name of the entity that ordered such quarantine or isolation (*e.g., a copy of the quarantine or isolation order*)

___ I have been advised by a health care provider to self-quarantine related to COVID-19

- If requesting paid sick leave for this reason, you must provide documentation supporting your request that includes:
 1. Name of the health care provider that ordered such quarantine (*e.g., a copy of your health care provider's advice to self-quarantine*)

___ I am experiencing COVID-19 symptoms and am seeking a medical diagnosis

- If requesting paid sick leave for this reason, you must provide documentation supporting your request that includes:
 1. Name of the provider from whom you are seeking a medical diagnosis
 2. Date on which you contacted the provider
 3. Copy of any response provided by the provider

___ I am caring for an individual (i.e., immediate family member, roommate, or your relationship to such individual creates an expectation that you would care for the person in the situation, etc.) subject to a Federal, State, or local quarantine or isolation order related to COVID-19

- If requesting paid sick leave for this reason, you must provide documentation supporting your request that includes:
 1. Name of the entity that ordered such quarantine or isolation (*e.g., a copy of the quarantine or isolation order*)

___ I am caring for an individual (i.e., immediate family member, roommate, or your relationship to such individual creates an expectation that you would care for the person in the situation, etc.) who has been advised by a health care provider to self-quarantine related to COVID-19

- If requesting paid sick leave for this reason, you must provide documentation supporting your request that includes:
 1. Name of the health care provider that ordered such quarantine or isolation (e.g., a copy of the health care provider's advice to self-quarantine)

___ I am caring for my Child(ren) whose school or Place of Care is closed (or Child Care Provider is unavailable) due to COVID-19 related reasons

- If requesting paid sick leave for this reason, you must provide the following:
 1. Name(s) and age(s) of Child(ren);
 2. Name(s) of school/Place of Care/Child-Care Provider closed or unavailable;
 3. A statement representing that no other suitable person is available for the Child(ren) during the requested leave
 4. Documentation supporting your request (e.g., the notice that has been posted on a government, school, or day care website, or published in a newspaper, or an email from an employee or official of the school, place of care, or child care provider)

___ I am experiencing a substantially-similar condition specified by the U.S. Department of Health and Human Services

- If requesting paid sick leave for this reason, you must provide documentation supporting your request

I, _____, with my signature below, certify that I need paid sick leave because I am unable to work or telework for the above-indicated reason. I also certify that the documentation I provide in support of my need for paid sick leave is true, accurate, and legitimate. I also certify that I will provide notification as soon as my reason for paid sick leave is no longer effective.

Signature: _____ Date: _____

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|---------------------------|---------------------|
| Supervisor Approval _____ | Date ____/____/____ |
| HR Approval _____ | Date ____/____/____ |