**EMERGENCY PAID SICK LEAVE**

**NOTICE AND REQUEST FOR LEAVE**

**Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**EXPLANATION OF EPSL BENEFITS**

The Families First Coronavirus Response Act (FFCRA) requires certain employers to provide their employees with paid sick leave for specified reasons related to COVID-19.

The Emergency Paid Sick Leave (EPSL) provisions in the FFCRA are effective from April 1, 2020 through December 31, 2020.

Generally, local public entities must provide employees up to two weeks of paid sick leave for certain qualifying reasons relating to COVID-19.

Employees who work 40 or more hours per week are eligible for 80 hours of EPSL. Employees who work fewer than 40 hours are eligible for the average number of hours they work in a two-week period.

**Healthcare Provider and Emergency Responder Exclusion:**

Healthcare providers and emergency responders, as defined by Department of Labor regulations are excluded from eligibility for EPSL.

**QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19**

An employee is entitled to take EPSL if the employee is unable to work or telework because:

(1) The employee is subject to a federal, state or local quarantine or isolation order relating to COVID-19;

(2) The employee has been advised by a healthcare provider to self-quarantine due to concerns related to COVID-19;

(3) The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis;

(4) The employee is caring for an individual who is subject to a quarantine or isolation order or who has been advised by a healthcare provider to self-isolate;

(5) The employee is caring for a son or daughter whose school or daycare has been closed due to COVID-19 or the child care provider is unavailable for reasons related to COVID-19;

(6) The employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

Employees who take EPSL for reasons (1), (2), or (3) are paid at 100% of their regular rate, capped at $511 per day/$5,110 in the aggregate. Employees who take leave for reasons (4), (5), or (6) are paid at 2/3 their regular rate, capped at $200 per day/$2,000 in the aggregate.

**EMPLOYEE REQUEST FOR EPSL BENEFITS**

I am requesting Emergency Paid Sick Leave (EPSL) as provided for in the Families First Coronavirus Response Act (FFCRA).

**Check applicable reason and provide additional information as indicated**. **See EPSL Policy for further explanation of each qualifying reason.**

**I certify that I am unable to work or telework for the following reason:**

\_\_\_\_\_ (1) I am subject to a federal, state or local quarantine or isolation order relating to COVID-19.

**Identify governmental entity that issued the order**:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_ (2) I have been advised by a healthcare provider to self-quarantine due to concerns related to COVID-19.

**Identify healthcare provider**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ (3) I am experiencing symptoms of COVID-19 and seeking a medical diagnosis.

\_\_\_\_\_ (4) I am caring for an individual who is subject to a quarantine or isolation order or who has been advised by a healthcare provider to self-isolate.

**Identify governmental entity that issued order**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

**Identify the healthcare provider who has advised individual to**

**self-isolate**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ (5) I am caring for a son or daughter whose school or daycare has been closed due to COVID-19 or the child care provider is unavailable for reasons related to COVID-19 and there is no other suitable person to care for my son or daughter.

**Name of son or daughter**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**School, daycare or child care provider**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ (6) I am experiencing another substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor. Verification requirements may vary. **Explain the condition in the space below**:

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

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Requested EPSL start date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested EPSL end date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that if I take EPSL for reasons (1), (2), or (3), I will be paid 100% of my regular rate or $511 per day/$5,110 in the aggregate, whichever is less.

I understand that if I take EPSL for reasons (4), (5), or (6), I will be paid 2/3 of my regular rate or $200 per day/$2,000 in the aggregate, whichever is less.

**Select Yes or No or Not Applicable:**

If I will be paid less than 100% of my regular wages for EPSL, I choose to supplement the EPSL with my existing paid leave benefits to bring my gross wages up to 100%.

Yes\_\_\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_\_\_ Not Applicable\_\_\_\_\_\_\_\_\_\_\_\_

**Complete if applicable**:

If I selected “Yes” above, I elect to use the following existing paid time off to supplement the EPSL:

\_\_\_\_\_\_\_Personal time

\_\_\_\_\_\_\_Sick time

\_\_\_\_\_\_\_Vacation time

\_\_\_\_\_\_\_Compensatory time off

Employee signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TO BE COMPLETED BY EMPLOYER:**

Request is:

\_\_\_\_\_\_\_ Granted

\_\_\_\_\_\_\_ Denied

Employer representative signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name and position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_