



EMERGENCY PAID SICK LEAVE AND EMERGENCY FMLA REQUEST FORM

Client Name	Client Number	Date
Employee Name	Employee Number	Employee Supervisor
Leave Start Date	Leave End Date	Total Hours Requested

I CERTIFY THAT AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASON:

- ☐ I am subject to a Federal, State or Local quarantine or isolation order related to COVID-19 that specifically prevents me from working
Name of the government entity issuing the order: _____
- ☐ I have been advised by a health care provider to self-quarantine because of concerns related to COVID-19.
Name of the advising healthcare provider: _____
- ☐ I have symptoms of COVID-19 and I am seeking (or have sought) a diagnosis.
- ☐ I am caring for another individual who is subject to quarantine or has been advised by a health care provider to self-quarantine related to COVID-19.
Name of person I am caring for and our relationship: _____
Name of the government entity issuing the order: _____
Name of the advising healthcare provider: _____
- ☐ I need to care for my child(ren) because their school or childcare provider is closed or unavailable because of COVID-19. I certify that no other suitable person is available to care for the child(ren) during the period of requested leave. If listed child is over 14, I further certify that there are special circumstances that require me to provide care for them.
Name(s) and age(s) of child(ren): _____
Name of closed school(s) or place(s) of care: _____
- ☐ I am experiencing other conditions substantially similar to COVID-19 as specified by the Department of Health and Human Services.

I certify that all the facts are true and correct to the best of my knowledge. If my request for a leave of absence is approved, I understand that I must abide by all the terms and conditions of my leave of absence. If I am unable to return to work on the specified date, I am to notify the Questco Client Administration Department of the change. Failure to notify the Questco Client Administration Department may result in my being absent without authorization. I understand that I may be required to use all paid leave available to me (i.e. sick days, vacation time, etc.) before an unpaid leave of absence can occur. I further understand that I am responsible for paying all insurance premiums and voluntary deductions for whatever benefit programs I am enrolled in at the time of the Leave of Absence, and failure to make these payments continuously and promptly could cause loss of all or part of these benefits until I have returned to active status with the Company. Such loss of coverage may have a negative effect on eligible benefits if I re-enroll after my Leave of Absence, especially in the area of pre-existing conditions. I will receive a statement of premiums due from the Questco Benefits Department.

Employee Signature: _____

Date: _____

TO BE COMPLETED BY AUTHORIZED COMPANY REPRESENTATIVE:

Is employee required to:

Pay their benefit premiums while on leave: ☐ Yes ☐ No

If no, will the Company be responsible for employee premiums ☐ Yes ☐ No

Authorized Company Representative

Signature

Date

Please submit this completed form to your Questco representative for processing.