



REQUEST FOR LEAVE - EMERGENCY PAID SICK LEAVE ACT (“EPSLA”) Pursuant to the Families First Coronavirus Response Act

INSTRUCTIONS: Please complete all sections of this form and submit to the Human Resources & Legal Services Department. Failure to provide the additional information may result in delaying/ denying your request for leave under the Emergency Paid Sick Leave Act (“EPSLA”). After HR receives and reviews the information, a determination of eligibility will be provided to you. If you have any questions (about this form or EPSLA leave), please contact HR.

Your name (Print):

First Middle Last

Address City State Zip

Phone Number

Job Title Regular work schedule

I. LEAVE DURATION

EPSLA is paid leave for a max of up to two (2) weeks.

- (1) Leave to begin on: _____
- (2) Leave to end on: _____
- (3) Have you used any EPSLA leave hours while working for any other employer since April 1, 2020?
Yes ___ No ___
- (4) If Yes to (3), please identify the other employer and the number of EPSLA leave hours used with that employer: _____

II. PLEASE IDENTIFY THE REASON(S) FOR LEAVE

(Initial) I CERTIFY that I am unable to work (or telework) because I:

- (1) ___ Am subject to a federal, state, or local quarantine or isolation order related to COVID-19.
- (2) ___ Have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
- (3) ___ Am experiencing symptoms of COVID-19 and seeking a medical diagnosis.
- (4) ___ Am caring for an individual who:
 - A. ___ is subject to a federal, state, or local quarantine or isolation order related to COVID-19; or
 - B. ___ has been advised by a health care provider to self-quarantine due to concerns related to COVID.
- (5) ___ Am caring for my child whose school or place of care has been closed or whose child care provider is unavailable for reasons related to COVID-19.
- (6) ___ Am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services.



III. INFORMATION/SUPPORTING DOCUMENTATION

(1) _____ I CERTIFY that I am unable to work (or telework) due to the COVID-19 reason(s) I indicated above. Please provide additional information including specific dates:

- a. _____
- _____
- _____
- _____
- _____
- _____

(2) _____ Name, title and address of the health care provider advising me to self-quarantine due to concerns related to COVID-19:

(3) _____ Name of the federal, state, or local governmental entity placing me in quarantine or isolation related to COVID-19:

- The name of the individual for whom I am caring and relation to me: _____

(4) _____ Name, title and address of the health care provider advising the individual for whom I am caring to self-quarantine due to concerns related to COVID-19:

- The name of the individual for whom I am caring and relation to me: _____

(5) _____ For caring for my child(ren) due to closure of school or place of care, or child care provider unavailability for reasons related to COVID-19:

- Name(s) and ages(s) of the child(ren): _____
- Name(s) of school(s) or place(s) of care that has been closed or name of care giver provider who is unavailable due to COVID-19 precautions: _____

- I confirm that no other person will be providing care for my child(ren) during the period for which leave is requested, and that if such child(ren) is older than fourteen, special circumstances exist requiring me to provide care.



IV. EFMLA ¹

Are you also requesting leave under the Emergency Family Medical Leave Expansion Act ("EFMLEA") for this requested leave period? Yes _____ No _____

If yes, please complete and submit an EFMLEA leave request form along with this form. Please note, if approved, leave under EPLSA and EFMLEA will run concurrently during such period.

Are you requesting intermittent leave? Yes _____ No _____

(If yes, please explain the requested intermittent periods of leave. There may be limitations on your ability to use intermittent leave. Applicable limitations will be discussed with you when your request is processed).

V. COMPENSATION

Reasons 1-3: If you are unable to work (or telework) for reasons due to a COVID-19 circumstance described in (1), (2), or (3) above, you will be paid at your regular rate of pay up to a maximum of \$511 per day.

Reasons 4-6: If you are unable to work (or telework) for reasons due to a COVID-19 circumstance described in (4), (5), or (6) above, you will be paid at 2/3 your regular rate of pay up to a maximum of \$200 per day.

If eligible for EPSLA under Reasons 4-6, I understand that paid leave will be at 2/3 of my regular pay not to exceed \$200 a day.

- Would you like to use your own Leave Time to make up the remaining 1/3rd of your salary? _____ Yes _____ No
- If you check NO, the remaining 1/3rd of your salary will be unpaid unless you use your available leave.
- If you checked YES above, please check the type of leave you would like to use (until exhausted) in accordance with District policy, Collective Bargaining Agreement, and/or Manual:
 Vacation/Non-work day: _____ Personal: _____ Unpaid time: _____

I CERTIFY that the information I have provided in this form is accurate and have attached documentation if required. I understand that it is my responsibility to notify Human Resources immediately if there is any change to my leave request above. I understand that *additional documentation or clarification of documentation may be required prior to making a final determination to approve or deny the leave requested.*

Signature of Employee

Date

HR OFFICE USE ONLY:

Eligible: _____ Not Eligible: _____

Executive Director of HR and Legal (Name Printed)

Date

Executive Director of HR and Legal (Signature)

¹ EFMLEA leave is only available for a qualifying event from April 1, 2020 through December 31, 2020.