## Employee Request

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates Requested for Leave:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This correspondence is to notify you of the facility’s decision to place you on Emergency Paid Sick Leave (EPSL) and/or Emergency Family Medical Leave (EFML), pending verification of the information below and your signed acknowledgement.

You may be eligible for both EPSL and EFML, but only for a total of twelve weeks of paid leave. The EPSL Act provides for two weeks of paid leave. If used in conjunction with EFML, this period covers the first ten workdays of EFML, which are otherwise unpaid under the EFML Expansion Act unless you elect to use existing vacation, personal, medical or sick leave under your employer’s policy. After the first ten workdays of EFML have elapsed, you will receive 2/3 of your [regular rate of pay](https://www.dol.gov/agencies/whd/fact-sheets/56a-regular-rate), up to the maximum allowable limit, for the hours you would have been scheduled to work in the subsequent ten weeks under the EFML Expansion Act

**Qualifying Reasons for Emergency Paid Sick Leave/Emergency Family Medical Leave:**

|  |  |  |
| --- | --- | --- |
| EPL Sick |  EPL Care | EPL Child |
| Quarantined by a government agency, and/or been advised by a health care provider to self-quarantine,The employee is experiencing symptoms of the virus and seeking a medical diagnosis. | If an employee is unable to work because of the need to care for:an individual subject to quarantine orthat person has been advised by a health provider to self-quarantine.Paid at 2/3 thirds of regular pay up to a maximum of $200 a day for 10 days | If an employee is unable to work because of the need to care for:a child whose school or daycare centers closed, or childcare provider is unavailable,   Paid at 2/3 thirds of regular pay up to a maximum of $200 a day and aggregate of     $12,000  |

## Type of Leave Requested:

[ ]  EPL Sick

* I need off because I am subject to a Federal, State or local quarantine or isolation order related to COVID- 19. The name of the governmental entity ordering quarantine is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* I need off because I have been advised by a health care provider to self-quarantine due to concerns related to COVID- 19. The name of the health care professional advising self-quarantine is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
* I need off because I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.
* I need off because I am 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.

[ ]  EPL Care

* I need off because I am caring for an individual who is subject to a Federal, State or local quarantine/isolation order or has been advised by a health care provider to self-quarantine. The name of the governmental entity ordering quarantine or health care professional advising self-quarantine is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. The name of the person in my care and their relation to me is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

[ ]  EPL Child

* I need off to care for my child(ren) whose school or place of care is closed, or whose childcare provider is unavailable. I certify that no other person will be providing care for the child during the period for which I am receiving family medical leave.

Child(ren)’s age(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child(ren)’s name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of school or place of care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If my child is over the age of fourteen and requires my care during daylight hours, the special existing circumstance(s) that require me to provide care are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Please read and initial the information below:

\_\_\_\_\_\_ I certify that I am unable to work, including by means of telework, for the above reason.

\_\_\_\_\_\_ If the need for the above changes, you will notify the company immediately to discuss returning to work.

\_\_\_\_\_\_ We will continue to pay the employer’s portion of your health insurance during the leave. You are still responsible for your portion of your health care benefits. [add additional information if needed]

I have read, understand and acknowledge the above information. Please initial above and sign below.

Employee Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Employer Authorization

Manager Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date request was received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[ ]  Request approved [ ]  Request denied for the reasons below: