Families First Coronavirus Response Act - Emergency Paid Sick / FMLEA Leave Request

Complete the following information and submit to your immediate supervisor prior to your requested leave or provide the following information verbally if you are unable to complete this form.

Employee Name [print]: _____ Date: _____, 2020

Position: _____ Supervisor: _____
Dates of requested leave: _____
The amount of Emergency Paid Sick Leave being requested is _____days [hours] (not to exceed two weeks).

I am requesting **Emergency Paid Sick Leave** because I am unable to work or telework due to the following:

1. _____ I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.
   Name of the government entity that issued the order: _____

2. _____ I was advised by a health care provider to self-quarantine due to concerns related to COVID-19.
   Name of health care provider who advised you to self-quarantine: _____

3. _____ I am experiencing symptoms of COVID–19 and seeking a medical diagnosis.

4. _____ I am needed to care for _____ [name/relationship to employee] who is subject to number 1 or 2 above.
   Name of the government entity that issued the order: _____ **OR**
   Name of health care provider who advised you to self-quarantine: _____

5. _____ I am caring for my child(ren) whose primary or secondary school or place of care has been closed, or my paid childcare provider is unavailable due to COVID–19.

   Name of child(ren): _____
   Name of the school, place of care, or child care provider: _____
   ___ I confirm that no other suitable person is available to care for my child(ren).

6. _____ I am experiencing a substantially similar condition specified by the secretary of health and human services.

I am requesting **Emergency FMLEA Leave** because I am unable to work or telework due to the following:

_____ I am needed to care for my child(ren) whose school or paid child care provider is closed or unavailable for reasons related to COVID-19.
Name of child(ren): _____
Name of the school, place of care, or child care provider: _____
___ I confirm that no other suitable person is available to care for my child(ren).

I affirm that the statements on this form are true and accurate.

Employee Signature _____ Date: _____, 2020

Supervisor Signature _____ Date: _____, 2020