REQUEST FOR EMERGENCY PAID SICK LEAVE

Employees requesting Emergency Paid Sick Leave (EPSL) pursuant to the Families First Coronavirus Response Act (FFCRA) may complete this form for review and processing. You must provide as much advance notice as is reasonably practicable. Upon completion of this form, submit it to the Benefits Office for processing:

Employee Name:

Employee ID:

Department:

Date Leave to Begin:

Estimated End Date:

I am requesting this leave due to the inability to work or telework because of one of the following (check the appropriate reason below):

1) I am subject to state, federal or local quarantine or isolation order related to COVID – 19. ☐
2) I have been advised by a health care professional to self-quarantine due to concerns related to COVID – 19. ☐
3) I have symptoms related to COVID – 19 and I am seeking a diagnosis. ☐
4) I am caring for an individual who is subject to 1) or 2) above. ☐
5) I need to care for my child because the child's school, care provider is closed or unavailable because of COVID – 19. ☐ Name of provider/school:
6) I am experiencing other conditions substantially similar to COVID – 19 as specified by the Secretary of Health and Human Services. ☐

Documentation to Submit Linked to the Reason Selected Above:

1) Name of government entity issuing order.
2) Name of health care professional advising self-quarantine.
3) Statement that you have symptoms of COVID – 19 and documentation that you are seeking a diagnosis.
4) Name of government entity ordering quarantine or the name of the health care professional advising self-quarantine. If the person subject to quarantine or advised to self-quarantine is not the employee, that person's name and relation to the employee.
5) In the case of a leave request based on a school closing or care provider unavailability, the following information is to be completed:
   a) Name of child (children)
   b) Age (Ages)
   c) I am the only one that will be providing care during the period of requested leave ☐
   d) If child or children are age 15 – 17, in regards to work or telework ability, explain circumstances in which care is needed.
6) Explain other condition experienced and documentation needed will be communicated.

Employee Signature:

Benefits Department Signature:

This form can be faxed to 301 644 – 5122 or emailed to Benefits.Office@fcps.org

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