



EMPLOYEE REQUEST FOR EMERGENCY PAID LEAVE / EMERGENCY FAMILY MEDICAL LEAVE EXPANSION

Please return this form directly to Melissa Beck in the Human Resource Department

TO BE COMPLETED BY THE EMPLOYEE:	
Employee Name: _____	
Home Address: _____	
Home Phone: _____	Email: _____
<p>_____ Employee is subject to a federal, state or local quarantine/isolation order related to COVID-19 <i>Name of the entity/official that issued the order: _____</i></p> <p>_____ Employee has been advised by a health care provider to self-quarantine related to COVID-19 <i>Name of the health care provider: _____</i></p> <p>_____ Employee is experiencing COVID-19 symptoms and is seeking a medical diagnosis <i>Employee must have symptoms of COVID-19 and be unable to work because the employee is taking affirmative steps to obtain a medical diagnosis, such as making, waiting for, or attending an appointment for a test for COVID-19</i></p> <p>_____ Employee is caring for an individual who is under a quarantine or isolation order or has been advised by a health care provider to self-quarantine <i>Name of the entity/official that issued the order or the name of the health care provider who advised the individual being cared for to self-quarantine: _____</i></p> <p>_____ Employee is caring for his or her child whose school or place of care is closed or unavailable due to coronavirus-related reasons <i>Child(ren) name: _____</i> <i>Name of school/childcare provider: _____</i></p> <p>_____ Employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services(HHS).</p>	
Anticipated Begin Date of Leave: _____	Anticipated Return to Work: _____
If Leave is requested intermittently or on a reduced schedule, indicate requested schedule below:	
<p>Do you wish to substitute paid leave for the first two weeks under the <u>Emergency Family Medical Leave Expansion</u>:</p> <p><input type="checkbox"/> Yes Sick Leave _____ Comp Time _____ Vacation _____ Emergency Paid Leave _____</p> <p><input type="checkbox"/> No</p>	
<p>I certify that I am unable to work because of the qualifying reason identified above. In addition, I attest that if requesting leave to provide care for a child, that no other suitable person is available to care for the child during the period of my leave request. Upon approval, the time off will be applied retroactively towards the total leave time allowed by law.</p> <p>Employee Signature: _____ Date: _____</p>	