EMERGENCY PAID SICK LEAVE AND EMERGENCY FMLA REQUEST FORM

Employee Name	Employee ID Number	Date
Title	Supervisor	Department
Leave Start Date	Leave End Date	Total Hours Requested
I CERTIFY THAT AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASON:		
 □ I am subject to a federal, state, or local quarantine or isolation order related to COVID-19 that specifically prevents me from working. Name of the government entity issuing the order: 		
I have been advised by a health care provider to self-quarantine because of concerns related to COVID-19. Name of the advising healthcare provider:		
☐ I have symptoms of COVID-19 and I am seeking (or have sought) a diagnosis.		
I am caring for another individual who is subject to quarantine or has been advised by a health care provider to self-quarantine related to COVID-19. Name of person I am caring for and our relationship:		
Name of the government entity issuing the order:		
OR Name of the advising healthcare provider:		
I need to care for my child(ren) because their school or childcare provider is closed or unavailable because of COVID-19. I certify that no other suitable person is available to care for the child(ren) during the period of requested leave. If listed child is over 14, I further certify that there are special circumstances that require me to provide care for them.		
Name(s) and age(s) of child(ren):		
Name of closed school(s) or place(s) of care:		
☐ I am experiencing other conditions substantially similar to COVID-19 as specified by the Department of Health and Human Services.		
I certify that the above information is truthful and understand that misrepresenting my need for leave is grounds for discipline, up to and including termination.		
Employee Signature:		
If signing electronically, please type your full name, followed by "e-signed."		