EMERGENCY PAID SICK LEAVE ACT
EMPLOYEE REQUEST FOR LEAVE FORM

This form must be completed and returned to RGSD Human Resources before any request for leave under the Emergency Paid Sick Leave Act ("EPSLA") will be approved. Questions about the EPSLA or this form should be directed to Monica Williams-Woods, Assistant Superintendent of Human Resources. You may be contacted to provide additional information necessary to process your leave request.

Employee Name: _____

Today's Date: _____

Reason for Leave Request

YOU are unable to work or telework because YOU:

- ☐ Are subject to a federal, state, or local quarantine or isolation order related to COVID-19
  - Provide the name of the federal, state, or local government entity issuing the order placing you in quarantine or isolation related to COVID-19:
    _____
- ☐ Have been advised by a health care provider to self-quarantine related to COVID-19
  - Provide the name of the health care provider advising you to self-isolate or self-quarantine for reasons related to COVID-19:
    _____
- ☐ Are experiencing COVID-19 symptoms and are seeking a medical diagnosis
  - Provide the name of the health care provider from whom you are seeking a medical diagnosis:
    _____
- ☐ Are caring for an individual subject to a federal, state, or local quarantine or isolation order related to COVID-19
  - Provide the name of the federal, state, or local government entity issuing the order placing the individual for whom you are caring in quarantine or isolation related to COVID-19:
    _____
  - Please provide the name of the individual for whom you are caring:
    _____
  - Confirm that the individual listed above is an immediate family member, a person who regularly resides in your home, or a similar person with whom you have a relationship that creates an expectation that you would care for that person if they were quarantined or advised to self-isolate. _____ (initial)
- ☐ Are caring for an individual who has been advised by a health care provider to self-quarantine related to COVID-19
  - Provide the name of the health care provider advising self-isolation for the individual for whom you are caring for reasons related to COVID-19:
    _____

- Please provide the name of the individual for whom you are caring:

  _____

- Confirm that the individual listed above is an immediate family member, a person who regularly resides in your home, or a similar person with whom you have a relationship that creates an expectation that you would care for that person if they were quarantined or advised to self-isolate. _____ (initial)

☐ Are caring for a child whose school or place of care is closed or whose childcare provider is unavailable for reasons related to COVID-19

- Child(ren)'s name(s) and age(s):

  _____

  _____

- Name(s) of school(s) or place(s) of care that has been closed or name of care giver who is unavailable:

  _____

  _____

- Confirm that no other person will be providing care for the child(ren) during the period for which you would be receiving EPSLA leave. _____ (initial)
- For a child 15 years of age or older, confirm that you are unable to work or telework during daylight hours because special circumstances exist requiring you to provide care. _____ (initial)
  Use of EPSLA for caring for a child runs concurrently with EFMLA. Please see the EFMLA request form. Please note, for EFMLA, you may elect to use any available School-provided paid leave instead of EPSLA for the first two weeks of EFMLA.

☐ Are experiencing any other substantially similar condition specified by the Secretary of Health and Human Services

- Provide the name of the health care provider from whom you are seeking a medical diagnosis:

  _____

Payment During Leave

EPSLA is paid leave for up to two weeks. EPSLA leave for your <u>own</u> personal quarantine or isolation order, or to a seek <u>your own</u> medical diagnosis, will be paid at your full regular pay up to a maximum of $511 per day. For all other qualifying reasons, EPSLA leave will be paid at 2/3rds your regular pay up to a maximum of $200 per day.

NOTE: The school will utilize accrued leave available under applicable school policies to supplement the 1/3rd pay differential UNLESS you check the following:

☐ I do not wish to use my available paid leave under School policy but rather, would prefer to be paid at the 2/3rd rate of pay (subject to the caps identified above) under the EPSLA.

Length of Leave

Date Requested Leave is to Begin: _____, 2020

Anticipated Date Requested Leave Will End: _____, 2020

> *EPSLA is only available for use from April 1, 2020 through December 31, 2020, and only for a qualifying reason occurring during that period. EPSLA is only available for two weeks.*

Are you Requesting Intermittent Leave: Yes ___ No ___

If yes, please explain the requested intermittent periods of leave:

_____

_____

_____

_____

(*The School will determine whether or under what conditions intermittent EPSLA will be allowed. Applicable limitations will be discussed with you when your request is processed.*)

Have you used any EPSLA hours since April 1, 2020?

Yes ___ No ___ Don't Know ____

If Yes, please identify the number of hours of EPSLA previously used:

_____

Certification

I certify that the information I have provided is true and correct. I understand that it is my responsibility to notify _____ immediately if there is any change to my leave request above.

_____ _____

Employee signature Date