Certification for Requesting COVID-19 Paid Sick Leave (EPSLA) and/or Expanded Family and Medical Leave (EFMLEA)

Employee Name: _____ Date: _____

Employee Email: _____ Cell Phone: _____

Leave Certification Questions:

- Have you been employed at least thirty days: Yes ☐ No ☐
- Please check the appropriate qualifying reason(s) below that bests reflects why you are requesting leave:

☐ 1. I am subject to a federal, state, or local quarantine or isolation order related to COVID-19;
☐ 2. I have been advised by a health care advisor to self-quarantine due to COVID-19 concerns;
☐ 3. I am experiencing COVID-19 symptoms and seeking medical diagnosis;
☐ 4. I need to care for an individual subject to a federal, state, or local quarantine or isolation order, or who was advised by a health care provider to self-quarantine due to COVID-19 concerns.
☐ 5. I need to care for my child because my child's school or place of care is closed, or the child's care provider is unavailable due to public health emergency, or
☐ 6. I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the secretary of Treasury and the Secretary of Labor. **Please note that there are no "substantially similar conditions" specified at this time by the Secretary of Health and the Secretary of Labor.**

Please attach the health care provider's written recommendation for # 2 or # 4. Provide the federal, state, or local quarantine or isolation order for # 1.

- Are you unable to work or telework (must be approved) for the reason(s) listed above? Yes ☐ No ☐

I am requesting Emergency Paid Sick Leave (EPSLA) (up to two-weeks for full-time employees, prorated for part-time employees) at full pay due up to $ 511 daily, and $ 5,110 in total to:

☐ (#1) A government issued quarantine or isolation order for myself
  - Name of the government entity that issued the order_____

☐ (#2) Advised to self-quarantine by a healthcare provider for myself
  - Name of Health Care Provider that provided advice._____

☐ (#3) A medical diagnosis after experiencing symptoms of C0VID-19 for myself
  - Name of Health Care Provider that provided advice._____

I am requesting Emergency Paid Sick Leave (EPSLA) (up to two-weeks for full-time employees, prorated for part-time employees) at 2/3 pay up to $ 200 daily, and $ 2,000 in total to:

☐ (#4) Care for an Individual that is subject to a government quarantine or Isolation order or has been advised by a health care provider to self-quarantine. Provide the name of the government entity that issued the order or Name of Health Care Provider that provided advice:_____

☐ (#5) Care for a son or daughter under the age of 18 because their school or place of care has been closed or the childcare provider is unavailable due to a COVID-19 related emergency.

☐ I am electing to utilize my sick time available in Skyward in conjunction with this leave so that I receive 100% of my regular rate. If this box is NOT checked, you will receive 2/3 pay under this leave.

I am requesting Emergency Family Medical Leave Expansion Act (EFMLA) coverage (up to 12 weeks leave-paid at 2/3 pay (up to $200 daily, and $ 12,000 in total) after 2 unpaid weeks, unless EPSLA is also used) to:

☐ (#5) Care for a son or daughter under the age of 18 because their school or place of care has been closed or the childcare provider is unavailable due to a COVID-19 related emergency,

☐ I am electing to utilize my sick time available in Skyward in conjunction with this leave so that I receive 100% of my regular rate. If this box is NOT checked, you will receive 2/3 pay under this leave election, after the 2-weeks unpaid (unless EPSLA is available and elected above).

The following information is required when requesting EFMLA and/or EPSLA. By requesting this leave I am stating that no other suitable person is available to care for the child.

Provide the name of the school that has closed or place of care that is unavailable:

_____

Name of Child:_____, Relationship to Child:_____Age:_____

If child is over 14, reason why such leave Is needed:_____

Name of Child:_____, Relationship to Child:_____Age:_____

If child is over 14, reason why such leave Is needed_____

- What date do you intend to: Begin your leave?_____End your leave? _____
- I am requesting to take this leave on an intermittent basis: Yes ☐ No ☐
  - What does your intermittent schedule request look like?

_____

_____

EMPLOYEE AUTHORIZATION

The information I have provided above is accurate, and I understand that by representing such leave I am stating that I am unable to work due to the selected reason above. I understand that I may be subject to disciplinary action, up to and including termination, should I be found to have fraudulently used these available leaves or used them inconsistent with the law.

I understand that after the amount of approved leave is exhausted. I must notify my supervisor and the Human Resources Specialist of my intent to return to work.

_____ _____

Employee Signature Date

Please contact Julie Toner @ jtoner@huronisd.org with any questions you may have.