Families First Coronavirus Response Act
Emergency Paid Sick Leave Request Form

Employee Name:_____

First Day of Leave:_____

Employee Contact: Cell_____ Employee Email:_____

Emergency Paid Sick Leave Act:

Provides employees with two weeks of paid sick time at the employee's regular rate of pay (capped at $511/day or total of $5110) if the employee is unable to work because the employee:
Please circle the number that applies-

1. Has been ordered by the government to quarantine or isolate because of COVID-19.
2. Has been advised by a health care provider to self-quarantine because of COVID-19.
3. Has symptoms of COVID-19 and is seeking a medical diagnosis.

Provides employees with two-thirds regular rate of pay (capped at $200/day) for two weeks if employee:
Please circle the number that applies -

4. Is caring for someone who is subject to a government quarantine or isolation order or has been advised by a health care provider to quarantine or self-isolate.
5. Needs to care for a son or daughter whose school or child care service is closed due to COVID-19 precautions.
6. Is experiencing substantially similar conditions as specified by the secretary of health and human services, in consultation with the secretaries of labor and treasury

Is the employee full time? □ Yes □ No

Is employee part time? □ Yes □ No

If part time, what is the average number of hours the employee normally worked over a two week period or if variable hours scheduled, average number of hours worked for the prior two weeks or 6 months? _____avg. hours

Does the employee wish to use leave to fill in the other one-third of pay? □ Yes □ No

If so, please specify leave to be used and order of usage:

□ Yes □ first, second, third Sick leave
□ Yes □ first, second, third Vacation
□ Yes □ first, second, third Comp time

_____ _____
Employee Signature Date

_____ _____
Department Head Signature Date

Submit to the HR Department