

REQUEST FOR EMERGENCY PAID SICK LEAVE

FAMILIES FIRST CORONAVIRUS RESPONSE ACT

[Employer Legal Name and DBA if applicable] : _____

1. Employee Name (print): _____

2. The date or dates for which leave is requested: _____ - _____

By completing this form, I attest that I am unable to work or telework for the following reason (complete all form fields as applicable):

1// I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

Name of the government entity that issued the quarantine or isolation order: _____

2// I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

Name of the healthcare provider: _____

3// I am experiencing COVID-19 symptoms and seeking a medical diagnosis.

4// I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2).

Name of the government entity that issued the quarantine or isolation order or name of healthcare provider advising self-quarantine:

Name of Person in Need of Care:

Relation to Employee:

5// I am caring for a son or daughter whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19.

Name(s) of son(s) and/or daughter(s) being cared for: _____

Name: _____

Age: _____

Name: _____

Age: _____

Name: _____

Age: _____

Name of the school, place of care, or child care provider that has closed or become unavailable:

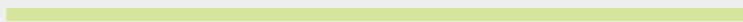
By completing this reason section above (number 5), I also affirm that that no other person will be caring for the above-named son(s) or daughter (s) during the period for which I am requesting paid sick leave. I further affirm that if the above-named son(s) and/or daughter (s) are over the age of 14 and care is needed during daylight hours that special circumstances exist requiring me to provide care.

6// I am experiencing a substantially similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.

7// I am seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, COVID-19 and have been exposed to COVID-19 or my employer has requested such test or diagnosis (this reason is only available from April 1, 2021 through September 30, 2021).

8// I am obtaining immunization related to COVID-19 (this reason is only available from April 1, 2021 through September 30, 2021).

9// I am recovering from any injury, disability, illness, or condition related to COVID-19 immunization (this reason is only available from April 1, 2021 through September 30, 2021).



I certify that the above information is true and correct.

Employee Signature

Date
