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 ____________________