|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. ***General Information*** | | | | | | | | | | | | | | | | | | |
| Employee Name: | | | | |  | | | | | | | | | | | Personnel #: | |  |
| Office Name: | | | | |  | | | | | | | | | | | Division: | |  |
| Job Title: | | | | |  | | | | | | | | | | | Phone #: | |  |
|  | | | | | | | | | | | | | | | | | | |
| 1. ***Employee Certification*** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  | | | **Employee Certification**:  I hereby certify I am unable to work, including telework. *Identify the specific limitations that prevent teleworking from home:* | | | | | | | | | | | | |  | | |
| Employee Initials | | |
|  | | | | | | | | | | | | | | | | | | |
| 1. ***Requested Hours and Reason for Emergency Sick Leave*** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Total # of Hours Requested: | | | | | | |  | | | | | *(80-hours maximum for full-time employees)* | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Qualifying Reason: *Insert an “X” next to applicable reason and provide requested information.* | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  |  | 1. | Employee is subject to a Federal, State or local quarantine or isolation order related to COVID-19. Proclamation Numbers 33 and 41 JBE 2020 (and any further Orders extending such) satisfy this provision only if the employee is unable to telework. | | | | | | | | | | | | | | | |
|  | | | *Identify applicable Order:* | | | | | |  | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
|  |  | 2. | Employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. | | | | | | | | | | | | | | | |
|  | | | *Health Care Provider’s Name:* | | | | | | | |  | | | | | | | |
|  | | | *Health Care Facility Name:* | | | | | | | |  | | | | | | | |
|  | | | *Health Care Facility’s Phone Number:* | | | | | | | | | |  | | | | | |
|  | | | *Date HCP Informed You to Self-Quarantine:* | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | |
|  |  | 3. | Employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis. | | | | | | | | | | | | | | | |
|  | | | *Health Care Provider’s Name:* | | | | | | | |  | | | | | | | |
|  | | | *Health Care Facility Name:* | | | | | | | |  | | | | | | | |
|  | | | *Health Care Facility’s Phone Number:* | | | | | | | | | |  | | | | | |
|  | | | *Date on Which You Sought Medical Diagnosis:* | | | | | | | | | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | |
|  |  | 4. | Employee is caring for an individual who is subject to qualifying reason 1 or 2 above. | | | | | | | | | | | | | | | |
|  | | | *Identify applicable Order:* | | | | | | | |  | | | | | | | |
|  | | | *Health Care Provider’s Name:* | | | | | | | |  | | | | | | | |
|  | | | *Health Care Facility Name:* | | | | | | | |  | | | | | | | |
|  | | | *Health Care Facility’s Phone Number:* | | | | | | | | | |  | | | | | |
|  | | | *Date HCP Informed Household Member to Self-Quarantine:* | | | | | | | | | | | | | |  | |
|  | | | | | | | | | | | | | | | | | | |
|  |  | 5. | Employee is caring for their son or daughter if the school or place of care has been closed or is unavailable due to COVID-19 precautions. | | | | | | | | | | | | | | | |
|  | | | *Name and Age of Child(ren):* | | | | | | |  | | | | | | | | |
|  | | | *School / Child Care Provider:* | | | | | | |  | | | | | | | | |
|  | | | *Provide an explanation regarding the lack of any other suitable person (such as other parent, grandparents, etc.) being available to care for the child. Include any “special circumstances” requiring you to care for the child during daylight hours if the child is over 14 years old.* | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | |
|  |  | 6. | Employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor. | | | | | | | | | | | | | | | |
|  | | | *Please explain:* | | |  | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 1. ***Requested Scheduling of Emergency Sick Leave*** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| Scheduling of emergency sick leave: *Insert a “X” next to only one option below and provide the requested information.* | | | | | | | | | | | | | | | | | | |
|  |  | 1. | | Continuous (include “From” and “To” dates): | | | | | | | | | |  | | | | |
|  |  | 2. | | Intermittent: ONLY available if for qualifying reason #5 and combined with teleworking from home. | | | | | | | | | | | | | | |
|  |  |  | | Provide requested intermittent work schedule, including # of hours/day, days of the week, duration, etc.  *(For example, request is to telework from home on Monday, Wednesday, Friday for 8 hours/day, with emergency sick leave on Tuesdays and Thursdays for 8 hours/day. This schedule would last from 4/1/2020 through the end of the school year on 5/20/2020.)* | | | | | | | | | | | | | | |
|  |  |  | | *Requested Intermittent Schedule:* | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| 1. ***Employee’s Typed Signature*** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| I certify that the above is true and accurate to the best of my knowledge. By typing “/S/My Name” to the right, I am electronically signing this form to request approval of emergency paid sick leave. | | | | | | | | | | | | | |  | /S/ | | | |
|  | | | | | | | | | | | | | |  | *Employee’s Typed Name as Signature* | | | |