

**EMPLOYEE REQUEST FOR EMERGENCY PAID SICK LEAVE  
FOR COVID-19 QUALIFYING REASON**

To request emergency paid sick leave under the Families First Coronavirus Response Act (FFCRA) and the County's *Emergency Paid Sick Leave and Emergency Family Medical Leave Expansion Policy Related to COVID-19*, you must complete this request form and submit it to the Human Resources Department as soon as possible. All requested information supporting the need for leave must be provided with this request.

**Notice:** If you are unable to submit the form prior to commencement of your leave, verbal notice will be accepted until this form and the required information can be provided. However, if you have not provided this form, after the first workday of paid sick time, you will be provided notice and given the opportunity to submit proper documentation to ensure your eligibility prior to any action being taken to deny your leave for failure to follow reasonable notice procedures.

**EMPLOYEE NAME**

Employee Name (print clearly): \_\_\_\_\_

Department: \_\_\_\_\_

Manager/Department Head: \_\_\_\_\_

**DATES OF LEAVE**

Requested Leave Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_

The amount of emergency paid sick leave being requested is \_\_\_\_\_ hours.

**QUALIFYING REASON FOR LEAVE**

I am requesting this emergency paid sick leave due to my inability to work (or telework) because (check the appropriate reason below):

1) I am subject to a federal, state, or local quarantine or isolation order related to COVID-19. If you have checked this box, please provide the name of the governmental entity issuing the quarantine or isolation order related to COVID-19:

\_\_\_\_\_  
Governmental Entity Issuing Quarantine or Isolation Order

2) I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. If you have checked this box, please provide the following information regarding the health care professional advising self-quarantine:

\_\_\_\_\_  
Name of Physician/Hospital/Clinic/Telemed Services Governmental Entity Issuing Quarantine or Isolation Order

\_\_\_\_\_  
Provider Address/Phone Number

\_\_\_\_\_  
Date of Service

3) I am experiencing symptoms associated with COVID-19 and seeking a medical diagnosis.

4) I am caring for an individual who is subject to a quarantine/isolation order or who has been advised to self-quarantine. If you have checked this box, please provide the full name of the individual subject to a quarantine or isolation order and the applicable information below:

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Full Name of Individual for Whom You Are Caring

*If the individual for whom you are caring is subject to quarantine/isolation order, please provide:*

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Governmental Entity Issuing Quarantine or Isolation Order

*If the individual for whom you are caring has been ordered to self-quarantine, please provide:*

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Name of Physician/Hospital/Clinic/Telemed Services Governmental Entity Issuing Quarantine or Isolation Order

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Provider Address/Phone Number

Date of Service

5) I am caring for my child (or children) whose primary or secondary school or place of care has been closed or my childcare provider is unavailable for COVID-19 reasons. If you have checked this box, please provide the following information:

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Full Name(s) and Age(s) of Child(ren)

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Name, Address, Phone Number of Unavailable School or Place of Care

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Names and Ages of Additional Children, if Any

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Name, Address, Phone Number of Additional Unavailable Schools or Places of Care

**Required Attestation Regarding Childcare:**

I attest that no other suitable person is available to care for my child(ren) during the requested period of leave.

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Employee Signature

Date

