

**Emergency Paid Sick Leave Act & FML Expansion
Request Form (COVID-19)**



Employee Name: _____ Empl ID: _____ Date: _____

Department: _____ Status: Faculty Staff Student

1. I am requesting emergency paid leave (up to 10 work days) at full pay due to:

- a government issued quarantine or isolation order for myself
- advised to self-quarantine by a healthcare provider for myself
- to obtain a medical diagnosis after experiencing symptoms of COVID-19 for myself

2. I am requesting emergency paid leave (up to 10 work days) at 2/3 pay to:

- care for an individual that is subject to a government quarantine or isolation order or has been advised by a health care provider to self-quarantine
- care for a for a child subject to a school or daycare closure

3. I am requesting FMLA Expansion coverage (up to 12 weeks, paid at 2/3 pay after 10 days) to:

- care for a son or daughter under the age of 15 if their school or place of care has been closed or the child care provider is unavailable due to a COVID-19 related emergency.

4. I choose to supplement my 2/3 pay for the above care for other reason with the following leave (not required):

- vacation
- sick
- personal
- Other _____

5. Name and address of healthcare provider or school/childcare provider:

EMPLOYEE AUTHORIZATION

I understand that I must provide medical documentation from a healthcare provider, if it is due to a medically ordered quarantine, isolation or medical directive to obtain a medical diagnosis for myself or to care for an individual that is subject to a quarantine or isolation order. Government issued quarantine or isolation orders do not require medical documentation. I understand that all information obtained during this process will be maintained and used in accordance with confidentiality requirements.

Employee Name and Signature: _____ Date: _____

SUPERVISOR ACKNOWLEDGEMENT

I acknowledge that this employee has notified me that they are seeking approval of Emergency Paid Sick Leave Act & FML Expansion. I have reviewed any required documentation and approve the request.

Supervisor Name and Signature: _____ Date: _____

HUMAN RESOURCES ACKNOWLEDGEMENT

I acknowledge that this employee has notified me that they are seeking approval of Emergency Paid Sick Leave Act & FML Expansion. I have reviewed any required medical documentation and approve the request.

HR Approver Name and Signature: _____ Date: _____