



## 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 child subject to a school or daycare closure

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

- vacation
- sick
- personal
- other \_\_\_\_\_

**3. I am requesting FMLA Expansion coverage (up to 12 weeks) to:**

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

**I choose to use the following leave (specify order in which leave is to be used, if applicable):**

- vacation \_\_\_\_\_
- sick \_\_\_\_\_
- personal \_\_\_\_\_
- other \_\_\_\_\_

**Leave will be taken:**

- intermittently (specify leave hours per week) \_\_\_\_\_
- full time

**4. 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 the confidentiality requirements.

Employer 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 approved 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: \_\_\_\_\_