

EMERGENCY PAID SICK LEAVE REQUEST

Employees requesting Emergency Paid Sick Leave (EPSL) pursuant to the Families First Coronavirus Response Act (FFCRA) must complete this form. You must provide as much advance notice as is reasonably practicable. Upon completion of this form, submit it to Human Resources for processing.

Employee Name:	
Employee Home Address:	E-mail:
Home Phone Number:	Cell Phone Number:
Anticipated Begin Date of Leave:	Expected Return to Work Date:
Reason for Leave (<i>check all applicable</i>) I am unable to work (or telework) for the following reasons: <input type="checkbox"/> I am subject to state, federal or local quarantine or isolation order related to COVID-19 (Document source of any quarantine or isolation order): _____ <input type="checkbox"/> I have been advised by a health care professional to self-quarantine due to concerns related to COVID-19 (Health care provider's name): _____ <input type="checkbox"/> I have symptoms related to COVID-19 and I am seeking a diagnosis (Healthcare Provider's Name): _____ <input type="checkbox"/> I am caring for an individual who is subject to quarantine or has been advised to quarantine related to COVID-19 (Document source of any quarantine order): _____ <input type="checkbox"/> I need to care for my child under age 18 because the child's school, childcare or childcare provider is closed or unavailable because of COVID-19 (Document of school closure or childcare closure): _____ <input type="checkbox"/> I am experiencing other conditions substantially similar to COVID-19 as specified by Health and Human Services.	
I will need (<i>choose one</i>): <input type="checkbox"/> Continuous leave <input type="checkbox"/> Intermittent leave	
If your need for leave is intermittent, please describe the nature of your intermittent leave: _____	

I certify that the above information is accurate and complete and have provided the necessary documentation to support of my request for leave. I understand that if I fail to report for work on or before the scheduled return date indicated above or fail to contact Human Resources regarding my absence from work beyond such scheduled date of return, my employer may take corrective action.

Employee Signature: _____ **Date:** _____

Human Resources Signature **Date:** _____

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For further assistance call or visit www.mcclone.com | 800.236.1034