# Application for EPSLA and EFMLEA Paid Leave

**Instructions to Employee**: Please complete this form fully and completely. You are required to provide timely, complete, and sufficient certification to support a request for paid leave pursuant to the Emergency Paid Sick Leave Act (EPSLA) and the Emergency Family and Medical Leave Expansion Act (EFMLEA). Be as specific as you can; terms such as “unknown,” or “indeterminate” may not be sufficient to determine eligibility for coverage. Your response is required to obtain a benefit. Failure to do so may result in denial of paid leave. You are provided 15 calendar days from the date of your request for paid leave to return this to your employer.

This form is to be used unless and until the Department of Labor or other governing body provides otherwise, at which time such form(s) will supersede and replace this.

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Supervisor Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Request: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anticipated End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Check the situation for which you are applying for leave:

\_\_\_ I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

Start date and end date of ordered self-quarantine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide any written self-quarantine order issued by your healthcare provider.

**OR**

\_\_\_ I am experiencing symptoms of COVID-19 and I am seeking medical diagnosis from the following health care provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and understand I have to give HR updates on my attempts to get a diagnosis.

**OR**

\_\_\_ I am caring for an individual who has been advised to self-quarantine by a health care provider due to concerns related to COVID-19.

Start date and end date of ordered self-quarantine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide any written self-quarantine order issued by the individual’s healthcare provider.

**To be completed if any of the above reasons are marked:**

Health Care provider’s name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health care Provider Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If Applicable:**

Name of Individual I am caring for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to me: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**OR**

\_\_\_ I am caring for my son or daughter whose school (or childcare facility) was closed (or unavailable) due to COVID-19 precautions

Name of Facility or School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Facility or School \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Age of Child (ren) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expected dates of leave \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If leave is related to a school or childcare facility closing, please include any available documentation verifying the closure, which may include: a notice that has been posted on a government, school, or day care website; a newspaper publication; or an email from an employee or official of the school, place of care, or child care provider.

**OR**

\_\_\_I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

Start date and end date of ordered quarantine or isolation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please provide the written quarantine or isolation order. (Please note that a general order does not qualify employees for paid leave, but specific orders directed to you may render you eligible for paid leave.)

**OR**

\_\_\_\_ I am experiencing a substantially similar condition specified by the HHS in consultation with Departments of the Treasury and the DOL.

Please specify and provide any available documentation:

**Certification:**

I certify that I am unable to work, including telework for the reasons mentioned above and that the information is true and accurate. I understand that failure to provide complete and sufficient certification and documentation may result in denial of paid leave.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature Date

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HR Approval Payroll Approval