

EMERGENCY PAID SICK LEAVE REQUEST (EPSL)

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 HR@Employerflexible.com for processing.

Employee Name:	Company 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 certify am unable to work (or telework) for the following reason(s): <ul style="list-style-type: none"> <input type="checkbox"/> 1. I am subject to state, federal or local quarantine or isolation order related to COVID-19 <input type="checkbox"/> 2. I have been advised by a health care professional to self-quarantine due to concerns related to COVID-19 <input type="checkbox"/> 3. I have symptoms related to COVID-19 and I am seeking a medical diagnosis <input type="checkbox"/> 4. I am caring for an individual who is subject to quarantine or has been advised to quarantine related to COVID-19 <input type="checkbox"/> 5. I need to care for my son or daughter under age 18 whose school or place of care has been closed (or childcare provider is unavailable) due to a public health emergency with respect to COVID-19. <input type="checkbox"/> 6. I am experiencing other substantially similar conditions specified by the Secretary of Health & Human Services. 	
I will need (choose one): <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:	
<input type="checkbox"/> I have attached documentation to support my request for EPSL to this form. <input type="checkbox"/> I have not attached documentation to support my request for EPSL to this form.	
<input type="checkbox"/> I understand that I will be responsible for any health benefit deductions and understand they will be deducted per pay period. I understand that the full details of the Emergency Paid Sick Leave can be found at https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave	
<input type="checkbox"/> I certify that my employer has stated that I am unable to telework.	
Employee Initials	

I certify that the above information is accurate and complete. 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 (or Designated Company Representative): _____

Date: _____