EMERGENCY PAID SICK LEAVE (EPSL) / EMERGENCY FAMILY & MEDICAL LEAVE (EFML) REQUEST

Employees requesting Emergency Paid Sick Leave (EPSL) or Emergency FMLA (EFMLA) 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 Phone Number:	**E-mail:**
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):

- ☐ 1. I am subject to state, federal or local quarantine or isolation order related to COVID-19
- ☐ 2. I have been advised by a health care professional to self-quarantine due to concerns related to COVID-19
- ☐ 3. I have symptoms related to COVID-19 and I am seeking a medical diagnosis
- ☐ 4. I am caring for an individual who is subject to quarantine or has been advised to quarantine related to COVID-19
- ☐ 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.
- ☐ 6. I am experiencing other substantially similar conditions specified by the Secretary of Health & Human Services.
- ☐ 7. I am obtaining an immunization related to COVID-19 or recovering from any injury, disability, illness, or condition related to such immunization
- ☐ 8. I am seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, COVID-19 due to exposure to COVID-19 or my employer has requested such test or diagnosis.
- ☐ 9. 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.

I will need *(choose one)*: ☐ Continuous leave ☐ Intermittent leave

If your need for leave is intermittent, please describe the nature of your intermittent leave:

☐ **I have attached documentation to support my request for EPSL/EFML to this form.**

☐ **I have not attached documentation to support my request for EPSL/EFML to this form but will provide documentation within 10 days of this request. I understand that if I fail to provide the requested documentation, my absences may not be covered by the FFCRA and may not be paid** (*unless not required by your City or State laws*).

☐ **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**

☐ **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: _____