



Emergency Paid Sick Leave & Expanded Family Medical Leave Request

Part I – Employee Information

Name	Department									
Date of Hire	FTE	☐ Faculty	☐ Staff		☐					
Are you currently working on campus?		☐ Yes ☐ No	If yes, how many hours per week?							
Are you currently teleworking?		☐ Yes ☐ No	If yes, how many hours per week?							

Part II - Reason for Emergency Paid Sick Leave

☐ Employee is subject to a Federal, State, or local quarantine or isolation order. Name of government entity:	☐ Employee is experiencing symptoms of COVID-19 and is seeking medical diagnosis. Name of health care provider:
☐ Employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. Name of health care provider:	☐ To care for an individual who is subject to a Federal, State, or local quarantine or isolation order. Name of government entity: Name of individual and relationship to employee:
☐ To care for an individual advised by a health care provider to self-quarantine due to concerns related to COVID-19. Name of health care provider: Name of individual and relationship to employee:	☐ Caring for your child(ren) whose school or place of care is closed, or childcare provider is unavailable due to COVID-19 related reasons Name and age of child(ren): Name of school, place of care, or childcare provider:

Part III – Expanded Paid Family Medical Leave

☐ Caring for your child(ren) whose school or place of care is closed, or childcare provider is unavailable due to COVID-19 related reasons.	Name and age of child(ren): Name of school, place of care, or childcare provider:
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The initial 2-week period of leave is unpaid. By choosing one of the options below, I am directing the University to use the following form(s) of paid leave in lieu of being unpaid during this initial 2-week period (not required):

☐ Emergency Paid Sick Leave	☐ Accrued/Paid Leave	☐ Other:
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By signing below, I attest that no other suitable person is available to provide care for my child(ren) during the period for which I am receiving Expanded Paid Family Medical Leave.

Employee Signature	Printed Name	Date
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Part IV - Leave Period

Date Leave Will Commence:	Return to Work Date:	Total Days Requested:
Are you requesting intermittent leave or a reduced work schedule? ☐ Yes ☐ No		
If yes, when will you be unavailable to work?		

Part V - Signatures**Employee**

Signature

Printed Name

Date

Manager

Signature

Printed Name

Date

Department Head/Chair

Signature

Printed Name

Date

Part VI – Office of Human Resources**Request for Emergency Paid Sick Leave**☐

Approved

Number of Days Approved:

☐

Disapproved

If disapproved, why:

Request for Expanded Paid Family Medical Leave☐

Approved

Number of Days Approved:

☐

Disapproved

If disapproved, why:

Signature

Printed Name

Date