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:**

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:**

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**

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

Department Head or 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