

COVID-19 EMERGENCY SICK LEAVE

(April 1, 2020-December 31, 2020)

Name _____ School/Work Center _____

Hours requested _____ Dates _____ Job title _____

Telephone number(s) _____

Reason for Paid Sick Leave Request
<input type="checkbox"/> I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19, appropriate documentation may be required.
<input type="checkbox"/> I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. Appropriate documentation from health care provider may be required.
<input type="checkbox"/> I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis. Appropriate documentation from health care provider may be required.
<input type="checkbox"/> I am caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or has been advised by a health care provider to self-quarantine due to concerns related to COVID-19 (2/3 regular rate of pay). Appropriate documentation from health care provider may be required. <input type="checkbox"/> I would like to use any accrued leave to make up the 1/3 difference.
<input type="checkbox"/> I am caring for my child because the school or place of care has been closed, or the childcare provider is unavailable, due to COVID-19 precautions, (2/3 regular rate of pay). Appropriate documentation from childcare provider may be required. <input type="checkbox"/> I would like to use any accrued leave to make up the 1/3 difference.
<input type="checkbox"/> I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor, (2/3 regular rate of pay). Appropriate documentation from health care provider may be required. <input type="checkbox"/> I would like to use any accrued leave to make up the 1/3 difference.

I certify that I am unable to work (telework) due to the reason marked above. I understand that falsification of any information regarding this absence may be grounds for disciplinary action, including termination.

Employee Signature: _____ Date: _____

Approved by: _____ Date: _____

Note: First Responders and certain Health Care Providers May Be Excluded from Coverage Under the Emergency Paid Sick Leave Act.

School Secretary

Date of leave requested _____ and number of hours _____
First day of EMERGENCY leave granted _____ and number of hours _____
Last day of EMERGENCY leave granted _____ and total number of hours _____
Available hours remaining for employee's EMERGENCY sick leave _____