EMERGENCY PAID SICK LEAVE ACT (EPSLA) & EMERGENCY FAMILY MEDICAL LEAVE ACT (EFMLA) REQUEST FOR

St. Croix Central School District’s Emergency Paid Sick Leave Act (EPSLA) & Emergency Family Medical Leave Act (EFMLA) policies for more information.

St. Croix Central School District requires all EPSLA & EFMLA leave requests to be made using this form. Forms must be accompanied by substantiation documentation to support the requested leave.

Once completed, submit the form to the Human Resources Department, which will review and process your request.

**EMPLOYEE INFORMATION**

Employee Name: Leave request submission date:

Date of hire: Leave start date:

Position and department: Anticipated duration of leave:

**REASON FOR LEAVE**

Select the reason for requested leave. All leave requests require documentation to validate the request for leave as required by the Department of Labor. *Examples of valid substantiations are highlighted after each Reason for leave.*

\_\_\_\_\_\_ (1) The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19. *Copy of the quarantine or isolation order.*

Name of government entity that issued the quarantine or isolation to which you are subject.

\_\_\_\_\_\_ (2) The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. *Provider written recommendation to quarantine.*

Name of health care provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ (3) The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis. *Provider documentation regarding pursuit of diagnosis.*

Name of health care provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ (4) The employee is caring for an individual who is subject to an order as described in (1) or

has been advised as described in (2). *Provider written recommendation to quarantine.*

Name of cared for individual:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_ (5) The employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Service in consultation with the Secretary of the Treasury and the Secretary of Labor. *Provider written recommendation to quarantine.*

\_\_\_\_\_\_ (6) The employee is caring for a son or daughter of such employee if the school or place of care of the son or daughter has been closed, or the child care provider of such son or daughter is unavailable, due to COVID-19 precautions. *Copy of a public notice regarding shut-down, communication from school or child-care facility, notice in the newspaper.*

Name of cared for individual:

Relationship:

\_\_\_\_\_\_\_\_\_ (Initial) – by requesting this leave, I represent that no other suitable person is available to care for the child during the period of requested leave.

**ACKNOWLEDGEMENT AND SIGNATURE**

I acknowledge that I have read this request form and accurately completed it. Signature on this form is an acknowledgement that I am unable to work due to the Reason for Leave indicated on this form.

Employee Signature Date