WILLIAMS COUNTY SCHOOL DISTRICT #8

REQUEST FOR EPSL and/or EFMLA LEAVE

under the Families First Coronavirus Response Act (FFCRA) through 12/31/2020

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requesting:

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  | EPSL (Emergency Paid Sick Leave) | [ ]  | EFMLA (Expanded Family and Medical Leave) |

 *Only available under Reason for leave #5*

Date(s) of leave:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for leave *(Unable to work or telework)*:

|  |  |  |  |
| --- | --- | --- | --- |
| 1 | [ ]  | I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19, and I certify that I am unable to work because of that order. | Name of government entity *(Submit notification received)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2 | [ ]  | I have been advised by a health care provider to self-quarantine related to COVID-19, and I certify that I am unable to work because of that order. | Name of health care provider *(Submit notification received)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3 | [ ]  | I am experiencing COVID-19 symptoms and am seeking a medical diagnosis, and I certify that I am unable to work because of that order. | Name of health care provider and appointment date *(Submit notification received)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4 | [ ]  | I need to care for an individual subject to an order described in (1) or self-quarantine as described in (2), and I certify that I am unable to work because of that order. | Name of government entity or health care provider who advised the individual to self-quarantine *(Submit notification received)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5 | [ ]  | I need to care for my child(ren) whose school or place of care is closed (or child care is unavailable) due to COVID-19 related reasons; I certify that I am unable to work because of that situation and I affirmatively represent that no other suitable person will be caring for my child(ren) during the period for which I am requesting. | Name and age of child(ren) being cared for:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of school or child care provider that is unavailable *(Submit notification received)*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for benefits.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_