

## LEAVE REQUEST FORM—EMERGENCY PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE

Name	
Department/campus	Position
Email	Phone number
Date	Duration of leave <i>(specify dates requested)</i>

Leave benefits under the Families First Coronavirus Response Act (FFCRA) apply for the limited time period of April 1, 2020, to December 31, 2020. The amount of paid leave an employee may receive will vary depending on the reason leave is taken. Detailed information is available in the Employee Rights notice that can be found on the Human Resources tab on the Marshall ISD website.

An employee requesting emergency paid sick leave and expanded family and medical leave must complete this form and return it to Cynthia Dawkins in the Human Resources office as soon as the need for leave is identified. Documentation supporting the need for leave should be included when the request is submitted.

Emergency Paid Sick Leave (EPSL) is limited to 80 hours of paid leave at the following rates:

- Self: regular rate of pay up to \$511 per day
- For care of an individual or a son or daughter: two-thirds the regular rate of pay up to \$200 per day

Expanded Family and Medical Leave (EFML) provides up to 12 weeks of leave to care for a son or daughter when school is closed or child care is unavailable due to COVID-19. The first two weeks are unpaid, although the employee may access EPSL or other paid leave during this time. The remaining 10 weeks is two-thirds the regular rate of pay up to \$200 per day.

I request leave for the following reason(s):

### Self

\_\_\_ I'm subject to a federal, state, or local quarantine or isolation order related to COVID-19.

Name of entity requiring quarantine or isolation: \_\_\_\_\_

\_\_\_ I've been advised to self-quarantine by a health care provider.

Name of health care provider requiring self-quarantine: \_\_\_\_\_

\_\_\_ I'm experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

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

\_\_\_ I'm experiencing any other substantially-similar conditions specified by the U.S. Department of Health and Human Services.

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**Care for other individual or child**

\_\_\_\_ I'm unable to work in order to care for a minor son or daughter because their school is closed or child care is not available due to COVID-19.

Name of school or child care facility: \_\_\_\_\_

Are you the only adult caring for the child(ren): \_\_\_\_yes \_\_\_\_no

Name and age of child(ren): \_\_\_\_\_

If the son or daughter is over the age of 14 describe special circumstance requiring the care:

\_\_\_\_\_

\_\_\_\_ I'm unable to work in order to care for an individual subject or advised to quarantine or isolate.

Name of individual: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

**Intermittent Leave**

*(for child care purposes or if employee is working remotely)*

\_\_\_\_ I'm requesting intermittent leave according to the following schedule:

\_\_\_\_\_

**Accrued leave use**

**EFML:**

\_\_\_\_ I understand I'm required to use my accrued state and local leave concurrently with EFML. When accrued leave is exhausted, I will receive 2/3 pay for any remaining EFML.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Designation** *(completed by HR Department and a copy provided to the employee):*

\_\_\_\_ The employee qualifies for EPSL.

\_\_\_\_ The employee does not qualify for EPSL.

\_\_\_\_ The employee qualifies for \_\_\_\_ weeks of EFML.

\_\_\_\_ The employee does not qualify for EFML.

<p><b>For office use only:</b></p> <p>Date of Employment _____</p> <p>Medical certification provided ____Yes ____ No</p> <p>Approved by: _____ Name and title</p> <p>Date: _____</p>
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