Code No. 409.2E1

EMERGENCY PAID SICK LEAVE REQUEST FORM UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA)

Name: _____

Anticipated Begin Date: _____

Expected Return to Work Date: _____

Employee Request for Leave at Full Pay

Employees satisfying one of the three standards noted below are eligible for two weeks of leave capped at 80 hours paid at the employee's full regular compensation rate. For a part-time employee it is the number of hours equal to the average number of hours that the employee works over a typical two-week period. Please select the applicable reason and follow the related instructions.

I am unable to work or telework for the following reasons:

___I am quarantined pursuant to Federal, State, or local government order.
___I am quarantined on the advice of a health care provider due to COVID-19 concerns.
___I am experiencing COVID-19 symptoms and seeking a medical diagnosis.

Please attach the applicable government order or documentation from medical provider corresponding to the item(s) selected. If you are experiencing symptoms and seeking a medical diagnosis, please identify your symptoms and the date of your medical appointment.

Employee Request for Leave at 2/3 Pay

Employees satisfying one of the three standards noted below are eligible for two weeks of leave capped at 80 hours paid at the 2/3 of the employee's regular compensation rate. For a part-time employee it is the number of hours equal to the average number of hours that the employee works over a typical two-week period. Please select the applicable reason and follow the related instructions.

I am unable to work or telework for the following reasons:

___ I need to care for an individual subject to quarantine pursuant to Federal, State, or local government order or advice of a health care provider due to COVID-19. I represent that no other person will be providing care for the individual during the period for which the I am receiving Emergency Paid Sick Leave.

Please attach the applicable government order or documentation from medical provider.

___ I am experiencing a substantially similar condition as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor.

Please attach the applicable government order or documentation from medical provider.

___ I am unable to work or telework because I need to care for my child under age 18 because my child's elementary or secondary school, childcare provider, or child's place of care has been closed or is unavailable due to COVID-19. During this period of unavailability or closure, I represent that no other person will be providing care for my child during the period for which I am receiving Emergency Paid Sick Leave.

If the age of one or more of the children is between 14 and 18, the following special circumstances exist requiring me to care for the child during daylight hours:

Please attach notice or documentation related to the unavailability of the school, daycare, place of care or person providing care to the child. The District reserves the right to request confirmation regarding the nature of the closure or unavailability.

lf you are requesting 2/3 paid leave in conjunction with Expanded Family Medical Leave to care for a child under the age of 18 affected by school or care closure due to COVID-19, please complete the "Expanded Family and Medical Leave Request Form' to submit with this form.

I acknowledge that the above information is true to the best of my knowledge.

Signed _____

Date _____

Note: This type of emergency paid sick leave is only available through passage of the federal Families First Coronavirus Response Act and will expire on December 31, 2020. After that date, this exhibit

should be removed from policy 409.2, as the benefit will no longer be available to employees.