Federal Paid Sick Leave & Expanded Family and Medical Leave Request Form

TO BE COMPLETED BY EMPLOYEE TO ASSESS ELIGIBILITY FOR LEAVE

EMPLOYEE NAME:

☐ I am requesting Paid Sick Leave because 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.	Date(s) for which leave is requested: The name of the entity that issued the order is:
☐ I am requesting Paid Sick Leave because I have been advised to self-quarantine due to COVID-19, and I certify that I am unable to work because of that order.	Date(s) for which leave is requested: The name of the health care provider who advised the employee to self-quarantine due to concerns related to COVID-19 is:
☐ I am requesting Paid Sick Leave because I am experiencing symptoms of COVID-19 and am seeking medical diagnosis from a health care provider, and I certify that I am unable to work because of that order.	Date(s) for which leave is requested: The name of the health care provider and date for my appointment is:
☐ I am requesting Paid Sick Leave because I am caring for *anyone else* who is subject to a governmental ordered quarantine or isolation order due to COVID-19 or who has been advised to self-quarantine due to COVID-19; and I certify that I am unable to work because of that order.	Date(s) for which leave is requested: The name of the entity that issued the order or the name of the health care provider who advised the individual to self-quarantine due to concerns related to COVID-19 is:
☐ I am requesting Paid Sick Leave because I am needed to care for my child because the child's school or caregiver have closed or become unavailable due to COVID-19, 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 during the period for which I am requesting.	Date(s) for which leave is requested: The name and age of the child being cared for is: The name of the school or child care provider that is unavailable is: [if my child is older than 14, there are special circumstances requiring me to provide care during daylight-work hours.]:

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.

Signature: Date: