Request for Emergency Paid Sick Leave or Expanded FMLA Leave

To request emergency paid sick leave or Expanded Family Medical Leave as provided under the Families First Coronavirus Response Act (FFCRA), please complete this form and submit to the Human Resources Department as soon as possible before leave commences. Requests may be emailed to Benefits@U-46.org or faxed to (847) 888-6990.

Employee Name (print clearly): ____

Employee ID Number: ______________ Building Site or Department: _________________________________

Administrator/Supervisor/Manager: ____

Requested Leave Start Date: ________________ End Date: __________________

The amount of emergency paid sick leave being requested is __________ hours or __________ days.

I am requesting this emergency paid sick leave due to my inability to work (or telework) because (check reason below):

❏ 1) I am subject to a federal, state, or local quarantine or isolation order related to COVID–19.
❏ 2) I have been advised by a health care provider to self-quarantine due to concerns related to COVID–19.
❏ 3) I am experiencing symptoms of COVID–19 and seeking a medical diagnosis.
❏ 4) I am caring for an individual who is subject to either reason number 1 or 2 above.
❏ 5) I am caring for my child whose primary or secondary school or place of care has been closed, or my childcare provider is unavailable due to COVID–19 precautions, and,

❏ I attest that no other suitable person is available to care for my child during the requested period of leave.

[*Optional:* If a full week is not needed for reason 5, please indicate the days needed and hours:]

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Appropriate documentation to support your leave must be provided below:

For reasons 1, 2 or 4 above**, please provide:**
The name of the governmental entity ordering quarantine or the name of the health care professional advising self-quarantine,

Agency Name or Health Care Professional ____

Address____

Telephone Number ____

If the person subject to quarantine or advised to self-quarantine is not the employee, please specify that person's name and relation to the employee.

Name____

Relationship to Employee_____________________________________

Employee Name ______________________________________ **Employee ID Number**____________

Leave taken for reasons 1, 2 or 3 above will be paid at 100% of regular pay, to a maximum of $511/day, up to 80 hours (full-time employees).

Leave taken for reasons 4 or 5 above will be paid at 2/3 of regular pay, to a maximum of $200/day. Check below if you wish to use your own available sick, personal or vacation days to supplement and receive full pay.

Please use my available: ______Sick Days ______Personal Days ______Vacation Days to supplement my 2/3 pay

For leave requests based on reason 5 above (caring for a child or children whose primary or secondary school or place of care has been closed), please provide:

Child's First Name	Child's Last Name	Child's Date of Birth	School or Place of Care that is Closed	Location of School of Place of Care

Employee signature below is attestation that no other person will be providing care for the child during the period for which the employee is receiving family medical leave.

If an employee is unable to work or telework because of a need to provide care for a child older than fourteen years old during daylight hours, please provide a statement detailing any special circumstances which exist requiring the employee to provide care.

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I understand that my signature below confirms that I am unable to work, including by means of telework if available, for such reason as stated above.

Employee Signature_______________________________________ Date_______________

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibit employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by these laws. To comply with the law, we are asking that you **not** provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact than an individual or an individual's family member sough or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

COMPLETED FORM SHOULD BE EMAILED TO BENEFITS@U-46.ORG OR FAXED TO 847-888-6990.

HR USE ONLY:

HR Case Manager_________________________ Request Approved ______YES ______NO

HR Approval____________________________ Employee Notified__________ Supervisor Notified_____________

Workforce entry date _____________ Comments____

Hours/Days paid of EPSL_____________________ Hours/Days paid of Extended FML______________________