

# AFTON CENTRAL SCHOOL

## Emergency Paid Sick Leave Request

The Families First Coronavirus Response Act (FFCRA) requires covered public employers to provide Emergency Paid Sick Leave (EPSL) to an employee who is unable to work or telework during the COVID-19 health crisis due to one or more of the six (6) criteria outlined below. This leave expires on December 31, 2020.

Under this type of leave, an employee is entitled to two (2) full weeks (ten (10) work days) of pay, with a maximum payment not to exceed eighty (80) hours of paid sick time (pro-rated for part-time employees).

Pursuant to the provisions of the Act, employees who meet the qualifying criteria outlined as either items 1, 2, or 3 below, are entitled to their regular daily rate of pay, to a maximum rate of pay not to exceed \$511.00 per day, with a maximum payment in the aggregate of \$5,110.00.

Employees who qualify for this benefit consistent with the criteria identified in Paragraphs 4,5, or 6 below, will only qualify for a daily rate of pay equal to 2/3 of their regular rate of pay, not to exceed \$200.00 per day, with a maximum aggregate of \$2000.00.

Note: 24 hour notice to your supervisor to use EPSL is required. This form and any required documentation must be submitted to your supervisor within five (5) days of the first day EPSL is used.

### Directions:

Employees would complete this form and submit it to their supervisor. The supervisor will keep a copy and forward the original to the Superintendent. The Superintendent will convey the information to the Business Office. The original form will be placed in the employees medical file for District record.

Teachers will indicate on their *Teacher Absence Slip* by checking the COVID-19 Supplemental Leave box and indicate EPSL (Emergency Paid Sick Leave).

Non-Instructional employees would indicate EPSL on their time card.

Please contact your supervisor with any questions.

**APPLICATION DATA**

I. Employee Data

- a. Name of Employee: \_\_\_\_\_
- b. Department: \_\_\_\_\_
- c. Job Title: \_\_\_\_\_

II. The Date(s) for which Such Leave is Sought:

\_\_\_\_\_  
\_\_\_\_\_

III. Qualifying Reason for Requesting Leave

A. Qualifying Criteria:

- 1. **\_\_\_ The employee is subject to a federal, state or local quarantine or isolation order related to COVID-19.**
  - Employee is required to provide the name of the governmental entity ordering quarantine, as well as written documentation verifying this order or directive.
    - a. Name of governmental entity: \_\_\_\_\_
    - b. Copy of directive (examples: statement from employer; state order; news article; etc.)
  
- 2. **\_\_\_ The employee has been advised by a health care provider to self-quarantine because of COVID-19.**
  - Employee is required to attach medical documentation from health care provider verifying this directive, to include their name, address and contact information.
    - a. Name of health care provider: \_\_\_\_\_
    - b. Address: \_\_\_\_\_
    - c. Contact information: \_\_\_\_\_
    - d. Dates of recommended self-quarantine: \_\_\_\_\_
    - e. Copy of directive attached.

3. \_\_\_ **The employee is experiencing symptoms of COVID-19 and is seeking a medical diagnosis.**

- Employee is required to provide documentation verifying that they have sought medical diagnosis, to include the name, address, and contact information of the health care provider.

- a. Name of health care provider: \_\_\_\_\_
- b. Address: \_\_\_\_\_
- c. Contact information: \_\_\_\_\_
- d. Date request for diagnosis made: \_\_\_\_\_
- e. Dates of self-quarantine: \_\_\_\_\_
- f. Date and findings of diagnosis: \_\_\_\_\_

**NOTE: An employee *may not* take paid sick leave under the FFCRA if they unilaterally decide to self-quarantine without medical advice, even if they have COVID-19 symptoms.**

4. \_\_\_ **The employee is caring for an individual subject or advised to quarantine or isolation.**

- Name of individual: \_\_\_\_\_
- Relationship to employee: \_\_\_\_\_
- Name of health care provider: \_\_\_\_\_
- Address: \_\_\_\_\_
- Contact information: \_\_\_\_\_
- Date of directive: \_\_\_\_\_
- Dates of quarantine or isolation: \_\_\_\_\_

**NOTE: To qualify for this benefit, the person being cared for must be a member of the employee's immediate family, a person who regularly resides in the employee's home, or a similar person with whom the employee has a relationship that creates an expectation that the employee would care for them in a quarantine situation.**

5.      **The employee is caring for a son or daughter whose school or place of care is closed, or child care provider is unavailable due to COVID-19 precautions.**

- The name and age of the child (or children) to be cared for: \_\_\_\_\_  
\_\_\_\_\_
- The name of the school(s) that has (have) closed or place of care that is unavailable (if more than one, please specify):  
\_\_\_\_\_  
\_\_\_\_\_
- Copy of written documentation of school closure or that place of care is closed.

**NOTE:**

- In order to qualify for this benefit, the ***employee alone*** must be providing care to child (or children). An employee would not be eligible for this benefit if both parents or another individual is present to care for their child(ren).

**Employee Verification:** I represent that no other person will be providing care for the child (or children) during the period for which benefits are sought:

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

\_\_\_\_\_  
Employee Signature

- In the case of a child (or children) ages 15 to 17, in order to qualify for this benefit, the employee must identify "***special circumstances***" requiring to provide such care.

**Special Circumstances** (please describe in detail):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6.      **The employee is experiencing substantially similar conditions as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.**

- Please describe in detail the basis upon which your request for paid leave is sought): \_\_\_\_\_

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B. Reason for Paid Leave Benefit:

To be considered for this benefit, the employee must provide the employer a written statement which outlines the reason for the request.

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IV. Employment Status During Period for Which Paid Leave is Sought

To be considered for this benefit, the employee must provide the employer a written statement which outlines the reason that they are unable to work, including unable to telework, during the period for which such benefits are sought.

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V. Employee Certification

I certify that I have read the criteria upon which an employee may qualify for Emergency Paid Sick Leave under the Families First Coronavirus Response Act (FFCRA), and that the information I have provided is true and accurate to the best of my personal knowledge.

Dated: \_\_\_\_\_, 2020

\_\_\_\_\_  
Employee

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**For Supervisor Use Only:**

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

Received by: \_\_\_\_\_

Title: \_\_\_\_\_

Date sent to Superintendent: \_\_\_\_\_

**For Superintendent Use Only:**

Date Received: \_\_\_\_\_

Date Business Office Notified: \_\_\_\_\_

Original to Employee's File: \_\_\_\_\_

Circle One:    Approved            Denied (Include documentation)            Need More Information