EMERGENCY PAID SICK LEAVE REQUEST FORM

Request must be made as soon as you know you will need to be off

Date: _____ Employment Start Date: _____ Length of Service: _____

Employee Name: _____

Address: _____ Cell Phone: _____

Start Date of EPSL: _____ Expected End Date: _____

INFORMATION CONCERNING MY REQUEST FOR EPSL

I certify that I am unable to work because I:

☐ **am subject to a federal, state, or local quarantine or isolation order related to COVID-19;**

☐ **have been advised by a healthcare provider to self-quarantine due to COVID-19;**

☐ **am experiencing symptoms of COVID-19 and seeking a medical diagnosis;**

☐ **am caring for an individual who is subject to a federal, state, or local quarantine or isolation order related to COVID-19, or who has been advised by a healthcare provider to self-quarantine due to COVID-19;**

☐ **am caring for a son or daughter whose school or place of care has been closed or whose childcare provider is unavailable to provide care due to COVID-19 precaution; or**

☐ **am experiencing any other substantially similar condition specified by the Secretary of Health & Human Services.**

I understand that I must provide documentation to support my request for EPSL with a certification within 10 days of this request as set forth in the Company's EPSL Policy. I understand that if I fail to provide the requested documentation, my absences may not be covered by the EPSLA, and will not be paid. I also acknowledge that if the company provides me the paid leave before it has received all requested documentation, the pay is viewed as an advance on wages unless or until the Company finally approves the leave; and if the leave is denied, I will owe the money back. (*Note: Not required if you work in San Francisco*)

Employee Signature: _____ Date: _____