**[Employer Legal Name and DBA if applicable]**

 **Request for Emergency Paid Sick Leave**

**Families First Coronavirus Response Act**

1. Employee Name (print): Click here to enter text.

2. The date or dates for which leave is requested:
Click here to enter a date. - Click here to enter a date.

**By completing this form, I attest that I am unable to work or telework for the following reason (complete all form fields as applicable):**

* **(1)** I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

Name of the government entity that issued the quarantine or isolation order:

Click here to enter text.

* **(2)** I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

Name of the healthcare provider:
Click here to enter text.
* **(3)** I am experiencing COVID-19 symptoms and seeking a medical diagnosis.
* **(4)** I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2).

Name of the government entity that issued the quarantine or isolation order or name of healthcare provider advising self-quarantine:
Click here to enter text.

Name of Person in Need of Care:
Click here to enter text.

Relation to Employee:
Click here to enter text.
* **(5)** I am caring for a son or daughter whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19.

Name(s) of son(s) and/or daughter(s) being cared for:

Click here to enter text.
Age: Click here to enter text.

Click here to enter text.
Age: Click here to enter text.

Click here to enter text.
Age: Click here to enter text.

Name of the school, place of care, or child care provider that has closed or become unavailable:

Click here to enter text.

By completing this reason section above (number 5), I also affirm that that no other person will be caring for the above-named son(s) or daughter (s) during the period for which I am requesting paid sick leave. I further affirm that if the above-named son(s) and/or daughter (s) are over the age of 14 and care is needed during daylight hours that special circumstances exist requiring me to provide care.

* **(6)** I am experiencing a substantially similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.
* (7) I am seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, COVID–19 and have been exposed to COVID–19 or my employer has requested such test or diagnosis.
* (8) I am obtaining immunization related to COVID–19.
* (9) I am recovering from any injury, disability, illness, or condition related to COVID-19 immunization.

 **I certify that the above information is true and correct.**

Click here to enter text.Click here to enter text.

**Employee Signature Date**