San Carlos Public Schools
Application for Paid Sick Leave Pursuant to the
Emergency Paid Sick Leave Act (EPSLA) or
Emergency Family Medical Leave Expansion Act(EFMLEA)

Name: ______________________________ Date: ______________

Address: ____

Phone #: ___________________________ Email: ______________

Position: ___________________________ Site: ______________

Anticipated Begin Date of Leave: ______________________________

Expected Return to Work Date: ______________________________

The EPLSA and/or EFMLEA provides paid sick leave to a district employee with a qualifying COVID-19 need *under certain specified circumstances* when an employee is unable to work or telework (if applicable).

I am unable to work due to the following circumstance(s) (**Please check below the circumstance(s) for which leave is being requested)**:

____ Employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19, (the "Coronavirus").

____ Employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

____ Employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.

____ Employee:

- Is caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

  OR

- Has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

____ Employee is caring for his or her son or daughter, (under the age of 18 years old or older but incapable of self-care because of a physical or mental disability), because the school or place of care of the son or daughter has been closed, or because the child care provider of such son or daughter is unavailable, due to COVID-19 precautions.

____ Employee is experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

Name of health care provider who advised the employee to self-quarantine for COVID-19 reasons **(if applicable)**:

Name of Federal, State or local authority which issued the quarantine or isolation order to which employee is subject **(if applicable)**:

Please specify if the quarantine or isolation order was issued to you (employee).

If you are **not** the individual subject to the quarantine or isolation order, please list below the name and relationship to you of the person subject to the order:

If you have noted above as the reason for leave your care for a son or daughter under the age of 18 or older but incapable of self-care because of a physical or mental disability, *please provide the following information:*

Name of child(ren):

Age of the child(ren):

Relationship of child(ren) to you:

School or child care provider which has either closed or become unavailable:

By signing this form, I certify that:

- no other suitable person is available to care for the child(ren), identified above, during the period of leave requested;
- no other person will be providing care for the child(ren) during the period for which I am receiving family medical leave; and
- for any child(ren) identified above who is older than 14 years of age, special circumstances exist which require me to provide care during daylight hours.

IF AVAILABLE please submit with this completed form any documentation you may have at this time supporting your request for leave which may include the following:

- Quarantine or isolation order
- Notice of closure for your child's school or child care facility
- Prescription record
- Physician's report

Dated this _________ day of _______________________ 2020.

I certify that the information contained within this form is true and correct to the best of my knowledge. I authorize the District to obtain and verify any necessary information regarding my request. I understand that providing false information my result in corrective action up to, and including, termination of my employment or other penalties as permitted by law.

____
Employee's Signature

To be Completed by District Personnel

Request is: ☐ Approved ☐ Denied

Staff member: ______________________________

Date: ______________________________