ARKANSAS STATE UNIVERSITY

EMERGENCY PAID SICK AND/OR EXPANDED FAMILY MEDICAL LEAVE REQUEST FORM

Employees may request Emergency Paid Sick Leave (EPSL) under the Families First Coronavirus Response Act (FFCRA) for the following six reasons:

1. Employee is subject to a Federal, State or local quarantine or isolation order related to COVID-19.
2. Employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
3. Employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.
4. Employee is caring for an individual who is subject to an order as described in 1 or has been advised as described in 2.
5. Employee is caring for a child of such employee if the school or place of care of the child has been closed or the childcare provider is unavailable due to COVID-19 precautions.
6. Employee is experiencing any other substantially similar condition specified by the Secretary of HHS, in consultation with the Secretaries of Treasury and Labor.

Expanded Family and Medical Leave (EFML) may be requested for the following reasons:

• Available for Reason 5 listed above only

Please provide the following information:

Full Name: _____ Employee ID Number: _____

Job Title: _____ Department: _____

Contact Phone Number: _____ Email: _____

Dates Leave Requested (Intermittent leave is not available): _____ to _____

Under which of the above-listed reasons do you qualify for paid leave? _____

Please answer the questions below that apply to the reason for which you are requesting paid leave:

Reason 1: If you are requesting leave for ***Reason 1***, which government entity entered the quarantine or isolation order to which you are subject? _____

Reason 2: If you are requesting leave for ***Reason 2***, please provide the name of the health care provider who advised you to self-quarantine. _____

Reason 3: If you are requesting leave for ***Reason 3***, there are no further questions to answer.

Reason 4: If you are requesting leave for ***Reason 4***, please provide: (a) the name of the government entity that issued the quarantine or isolation order to which the person you are caring for is subject or (b) the name of the health care provider who advised the person you are caring for to self-quarantine due to concerns related to COVID-19. _____

(continued on the next page)

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Reason 5: If you are requesting leave for ***Reason 5***, please provide:

- The name of the son or daughter you are caring for:
- The name of the school or place of childcare that is closed or the name of the childcare provider who is unavailable:
- Please type your name to sign here to certify the following: No other suitable person will be caring for my son or daughter identified above during the period for which I am requesting leave.
- This leave type pays 66.66% of your salary. Do you wish to supplement the remaining portion of your pay by utilizing your accrued annual leave?

◯ Yes ◯ No

Reason 6: If you are requesting leave for ***Reason 6*** , there are no further questions to answer.

NOTE: If approved, leave may begin to be used effective the first day of the request and the right to use such Paid Leave expires on December 31, 2020. Leave will not be granted prior to the initial request date.

I certify that the information I provided on this form is correct and true to the best of my knowledge.
I acknowledge that I am requesting leave under the Expanded FMLA and/or the Emergency Paid Sick Leave Act, and that my request may or may not be approved pending review of my eligibility under the FFCRA. I am requesting paid leave because I am unable to work my normal hours due to a qualifying COVID-19 related reason.

By typing my name to sign below I certify that I have read and agree with the above statements.

Name: Date: