



EMPLOYEE REQUEST FORM EMERGENCY PAID SICK LEAVE - EMERGENCY FMLA

Employees may be entitled to Emergency Paid Sick Leave (EPSL) and / or Emergency FMLA (EFMLA) in accordance with the Families First Coronavirus Response Act (FFCRA) if the employee satisfies eligibility standards. Employees can complete this form and submit it or any questions to the Benefits office at Benefits@everettsd.org.

Employee Name: _____

Employee ID number: _____ E-mail: _____

Work Location: _____ Position: _____

Anticipated First Day of Leave: _____ Expected Return to Work Date: _____

The following two leave options pertain to EPSL and the first two weeks of leave. Choose the section appropriate to your circumstances:

OPTION 1- EMPLOYEE REQUEST FOR LEAVE AT FULL PAY

Employees satisfying one of the three standards noted below are eligible for **two weeks** of leave capped at 80 hours **paid at the employee's full regular compensation rate**. For a part-time employee it is the number of hours equal to the average number of hours that the employee works over a typical two-week period. Please select the applicable reason and follow the related instructions.

I am unable to work or telework for the following reasons:

- ☐ I am quarantined pursuant to Federal, State, or local government order.
- ☐ I am quarantined on the advice of a health care provider.
- ☐ I am experiencing COVID-19 symptoms and seeking a medical diagnosis.

OPTION 2- EMPLOYEE REQUEST FOR LEAVE AT 2/3 PAY

Employees satisfying one of the three standards noted below are eligible for **two weeks** of leave capped at 80 hours **paid at the 2/3 of the employee's regular compensation rate**. For a part-time employee it is the number of hours equal to the average number of hours that the employee works over a typical two-week period. Please select the applicable reason and follow the applicable instructions.

I am unable to work or telework for the following reasons:

- ☐ I need to care for an individual subject to quarantine pursuant to Federal, State, or local government order or advice of a health care provider. I represent that no other person will be providing care for the individual during the period for which the I am receiving Emergency Paid Sick Leave.

Name(s) of the individual(s) being cared for: _____

- ☐ I am experiencing a substantially similar condition as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor.
- ☐ I am unable to work or telework because I need to care for my child under age 18 because my child's elementary or secondary school, childcare provider, or child's place of care has been closed or is unavailable due to a public health emergency. During this period of unavailability or closure, I represent that no other person will be providing care for my child during the period for which I am receiving Emergency Paid Sick Leave.

Name(s) and Age(s) of Child or Children: _____

If the age of one or more of the children is between 14 and 18, the following special circumstances exist requiring me to care for the child during daylight hours: _____

The following section pertains to EFMLA and up to 12 weeks of leave. Employees must have worked for Everett Public Schools for 30 days, and must not have exhausted their FMLA leave entitlement in the past 12 months to be eligible for EFMLA.

REASON FOR LEAVE

Employees satisfying the above EFMLA criteria and standards noted below are eligible for 12 weeks* of leave. The first two weeks of the leave are unpaid, however, the EPSL option indicated in the previous section will be applied to the two-week unpaid period unless the employee requests an alternate pay option, such as the use of their own sick or vacation leave. The remaining 10 weeks of leave are **paid at 2/3 of the employee's regular compensation rate**. Please select the applicable reason and follow the applicable instructions.

- ☐ I am unable to work or telework because I need to care for my child under age 18 because my child's elementary or secondary school, childcare provider, or child's place of care has been closed or is unavailable due to a public health emergency. During this period of unavailability or closure, I represent that no other person will be providing care for my child during the period for which I am receiving EFMLA.

Name(s) and Age(s) of Child or Children: _____

If the age of one or more of the children is between 14 and 18, the following special circumstances exist requiring me to care for the child during daylight hours: _____

CONTINUOUS OR INTERMITTENT LEAVE

After completing the first ten days of EFMLA, an employee may choose to take 10 weeks of continuous leave under EFMLA for the reason indicated above. Continuous leave means the employee will not complete any District duties during this period but will be compensated based on the option above.

An employee may also choose to take 10 weeks of intermittent leave. Intermittent leave means an employee will complete some District duties on a modified schedule as approved by the employee's supervisor. When using intermittent leave, the employee will receive full regular pay for hours worked and 2/3 of regular pay during periods on EFMLA unless supplemented in a manner noted above.

I am requesting (choose one): ☐ Continuous leave ☐ Intermittent leave

If your need for leave is intermittent, please describe the requested schedule for your intermittent leave:

Employee Certification and signature. I understand that:

- ☐ it is my responsibility to report all absences related to this leave via the Frontline Absence Management system **using the EPSL / EFMLA reason code** unless otherwise instructed and to work with my supervisor to arrange an appropriate substitute, if applicable;
- ☐ reporting these absences in the employee absence reporting system *does not* constitute approval of this leave of absence and that this request for leave of absence is subject to the terms and conditions of my collective bargaining agreement and/or Board/District policy;
- ☐ Human Resources will determine final approval of this request;
- ☐ upon return from leave I may be assigned to a position comparable to that which I held at the time this request for leave was approved.

Employee Signature: _____

Date: _____

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FOR SCHOOL DISTRICT USE ONLY

Request Received By: _____ Date: _____

Leave Approved By: _____ Date: _____