

Stephen F. Austin State University
Emergency Paid Sick Leave (COVID-19) Request Form

EMPLOYEE INFORMATION:

Name of Employee: _____

Employee ID: _____

Department: _____

First Date of Leave: _____

Are you currently telecommuting? Yes No

QUALIFYING REASON:

I am requesting Emergency Paid Sick Leave for the following reason [check only one]:

- ☐ (1) Subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

Name of government entity:

- ☐ (2) Advised by a health care provider to self-quarantine related to COVID-19.

Name of health care provider:

- ☐ (3) Experiencing COVID-19 symptoms and seeking a medical diagnosis.

- ☐ (4) Caring for an individual subject to an order described in (1) or self-quarantine as described in (2).

*Name of individual **and** government entity or health care provider:*

- ☐ (5) Caring for a child whose school or place of care is closed (or childcare provider is unavailable) for reasons related to COVID-19.

Name of school or child care provider:

- ☐ (6) Experiencing any other substantially similar condition specified by the Secretary of Health and Human Services.

ACKNOWLEDGEMENTS

I have read and understand the following terms of the Emergency Paid Sick Leave Act:

- *Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of **paid sick leave** at the employee's regular rate of pay (up to \$511/day) for qualifying reasons (1), (2), or (3);*
- *Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of **paid sick leave** at two-thirds the employee's regular rate of pay (up to \$200/day) for qualifying reasons (4), (5), or (6).*
- *The number of hours for which I receive paid sick leave is capped at a total of 80 hours, or a part-time employee's two-week equivalent, for all qualifying reasons.*

Employee Signature

Date