

**Certification for Requesting COVID-19 Paid Sick Leave**  
**And/or Expanded Family and Medical Leave**

Employee Name: \_\_\_\_\_ Date \_\_\_\_\_  
Employee Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Leave Certification Questions**

- Have you been employed for at least 30 days:     Yes     No
- Please check the appropriate qualifying reason(s) below that best reflects why you are requesting leave:
  - 1. I am subject to a federal, state or local quarantine or isolation order related to COVID-19;
  - 2. I have been advised by a health care provider to self-quarantine due to COVID-19 concerns;
  - 3. I am experiencing COVID-19 symptoms and seeking medical diagnosis;
  - 4. I need to care for an individual subject to a federal, state or local quarantine or isolation order or who was advised by a health care provider to self-quarantine due to COVID-19 concerns;
  - 5. I need to care for my child because the child's school or place of care is closed or the child's care provider is unavailable due to public health emergency; or
  - 6. I am 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. **\*Please note that there are no "substantially similar conditions" specified at this time by the Secretary of Health and the Secretary of Labor.**
- Are you unable to work or telework for the reason(s) checked above?     Yes     No
- If you are requesting leave based on #1, 2 and/or 4, provide below the name of the governmental entity ordering quarantine or isolation, or the name of the health care provider advising self-quarantine. If the person subject to quarantine or advised to self-quarantine is someone other than you, provide that person's name and relation to you. Please attached the health care provider's written recommendation for #2 or #4. Provide the federal, state or local quarantine or isolation order for #1.
- If you are requesting leave based on #3, please provide the symptom(s) you are experiencing and the affirmative steps (and dates of such steps) you are taking to obtain a medical diagnosis, such as making, waiting for or attending an appointment for a test of COVID-19. If you obtain a medical diagnosis, please provide that notice as soon as possible.
- If you are requesting leave based on #5, provide the information requested in each of the next three inquiries:
  - a. Provide the name and age of the child (or children) to be cared for, the name of the school that has closed or place of care that is unavailable
  - b. Do you represent that no care provider is available and no other person will be providing care for the child during the period for which you are receiving leave under #5:     Yes     No
  - c. If any child (or children) is older than fourteen (14), explain the special circumstances that exist requiring you to provide such care.
- What date do you intend to: Begin your Leave? \_\_\_\_\_ End your Leave? \_\_\_\_\_

**CERTIFICATION**

I certify that the information above is true and accurate to the best of my knowledge and that I will provide all necessary documentation requested by my Employer.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

List the <b>actual hours, date and wage paid</b> for Sick Leave: <b>Date of Sick Leave</b>	<b>Number of Hours of Sick Leave</b>	<b>Gross Wage Paid</b>

List the actual hours (if intermittent leave), starting/ending date of the week and wages paid for EFMLEA Leave: <b>Starting/Ending Date of Week</b>	<b>Intermittent Leave Hours (if applicable)</b>	<b>Gross Wage Paid</b>

State below the content of any conversations with the employee requesting the COVID-19 Sick Leave or EFMLA Leave:
