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

A. Have you been employed for at least 30 days: ☐ Yes ☐ No

B. 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;** or
- ☐ 7. I am seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, COVID-19 and I have been exposed to COVID-19; or
- ☐ 8. My employer has requested that I submit to a diagnostic test for, or a medical diagnosis of, COVID-19; or
- ☐ 9. I am obtaining immunization related to COVID-19 or recovering from any injury, disability, illness or condition related to such immunization

C. Are you unable to work or telework for the reason(s) checked above? ☐ Yes ☐ No

D. 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 professional 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 attach the health care professional's written recommendation for #2 or #4. Provide the federal, start or local quarantine or isolation order for #1.

E. If you are requesting leave based on #3 or #7, 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.

F. 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 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.

G. If you are requesting leave based on #9, please provide the date, time and location of your immunization and, if applicable, the symptom(s) you are experiencing as a result of the immunization and provide any medical diagnosis obtained.

H. What date do you intend to: Begin your Leave? _____ End your Leave? _____

CERTIFICATION

I certify that all of the information I have provided 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 **actual hours, date and wage paid** for Sick Leave: **Date of Sick Leave:**	**Number of Hours of Sick Leave:**	**Gross Wage Paid:**

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

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