



Request for paid sick leave under the Families First Coronavirus Response Act Form

I am requesting paid sick leave on _____ date(s)
(maximum 2 weeks) for the following qualifying reason (check one):

- (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 related to COVID-19;
- (3) I am experiencing COVID-19 symptoms and seeking a medical diagnosis;
- (4) I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
- (5) I am caring for a child whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19; or
- (6) I am experiencing any other substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.

For leave reasons (1), (2), or (3): employees taking leave are entitled to pay at their regular rate up to \$511 per day. For leave reasons (4), (5), or (6): employees taking leave are entitled to pay at 2/3 their regular rate up to \$200 per day.

Documentation of the reason for the leave is necessary, such as the source of any quarantine or isolation order, or the name of the health care provider who has advised you to self-quarantine. For example, this documentation may include a copy of the Federal, State or local quarantine or isolation order related to COVID-19 applicable to the employee or written documentation by a health care provider advising the employee to self-quarantine due to concerns related to COVID-19. All existing certification requirements under the FMLA remain in effect if you are taking leave for one of the existing qualifying reasons under the FMLA. For example, if you are taking leave beyond the two weeks of emergency paid sick leave because your medical condition for COVID-19-related reasons rises to the level of a serious health condition, you must continue to provide medical certifications under the FMLA.

By signing below, I certify that I am unable to work, including telework, for the reason indicated. In addition, I have viewed the required poster and general information here <https://www.dol.gov/agencies/whd/pandemic>.

Name (Printed)

Signature

Date

Submit completed request form and documentation to engstromg@sgate.k12.mi.us