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Weslaco Independent School District

Human Resources Department

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Dr. Priscilla Canales
Superintendent of Schools

LEAVE REQUEST FORM—EMERGENCY PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE

Name	**Employee ID**
Department/campus	**Position**
Email	**Phone number**
Date	**Duration of leave** *(specify dates requested)*

Leave benefits under the Families First Coronavirus Response Act (FFCRA) apply for the limited time period of April 1, 2020, to December 31, 2020. The amount of paid leave an employee may receive will vary depending on the reason leave is taken. Detailed information is available in the Employee Rights notice that can be found on the district's HR webpage at https://www.wisd.us/departments/human-resources.

An employee requesting emergency paid sick leave and expanded family and medical leave must complete this form and return it to the **Risk Management Department** as soon as the need for leave is identified. Documentation supporting the need for leave should be included when the request is submitted.

Emergency Paid Sick Leave (EPSL) is limited to 80 hours of paid leave at the following rates:

- Self: regular rate of pay up to $511 per day
- For care of an individual or a son or daughter: two-thirds the regular rate of pay up to $200 per day

Expanded Family and Medical Leave (EFML) provides up to 12 weeks of leave to care for a son or daughter when school is closed or child care is unavailable due to COVID-19. The first two weeks are unpaid, although the empoyee may access EPSL or other paid leave during this time. The remaining 10 weeks are two-thirds the regular rate of pay up to $200 per day.

I request leave for the following reason(s):

Self

____ I'm subject to a federal, state, or local quarantine or isolation order related to COVID-19.

Name of entity requiring quarantine or isolation: _____

____ I've been advised to self-quarantine by a health care provider.

Name of health care provider requiring self-quarantine: _____

____ I'm experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

Name of health care provider: _____

Care for other individual or child

____I'm unable to work in order to care for a minor son or daughter because their school is closed or child care is not available due to COVID-19. **(Provide supporting documentation from school/care facility.)**

Name of school or child care facility: _____

Are you the only adult caring for the child(ren): _____yes _____no

Name and age of child(ren): _____

If the son or daughter is over the age of 14 describe special circumstance requiring the care:

_____

____I'm unable to work in order to care for an individual subject or advised to quarantine or isolate.

Name of individual: _____ Relationship: _____

Name of health care provider: _____

Intermittent Leave

(Include if allowed by the employer for child care purposes or if employee is working remotely)

____I'm requesting intermittent leave according to the following schedule:

_____

OR

Intermittent use of leave for EPSL or EFML is **not permitted**.

Accrued leave use

EPSL:

(Include if allowed by the employer)

___ I choose to use accrued paid leave to supplement the 2/3 pay covered by EPSL so I receive 100 percent of my regular rate of pay.

EFML:

(Include if the employer requires concurrent use of leave with EFML)

___ I understand I'm required to use my accrued state and local leave concurrently with EFML. When accrued leave is exhausted, I will receive 2/3 pay for any remaining EFML.

Designation *(completed by HR Department and a copy provided to the employee)***:**

_____The employee qualifies for EPSL.

_____The employee does not qualify for EPSL.

_____The employee qualifies for _____ weeks of EFML.

_____The employee does not qualify for EFML.

For office use only:

Date of Employment _____

Medical certification provided _____Yes _____No

Approved by:_____
Name and title

Date:_____