Fairfax County PUBLIC SCHOOLS
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Employee Request for Emergency Paid Sick Leave (EPSL)

Date Received by Disability and Leaves: _____

To be completed by the employee

This form is used to request Emergency Paid Sick Leave (EPSL) for those employees who are unable to work due to circumstances related to to COVID-19. If additional leave is needed to care for child(ren) due to school/childcare closures, employees can apply for Emergency Family Medical Leave (E-FMLE). If you have a need for more extended leave because of personal illness or care for an immediate family member, Family Medical Leave (FMLA) programming may be of interest. You must provide as much advance notice as is reasonably practicable. Please submit your request to the Office of Benefit Services using instructions on the reverse side of this form.

Your Name (Last, First, Middle) _____ Date of Request _____

Your Home Address (street and apt. number) _____ City _____ State _____ Zip Code _____

Employee ID Number _____ Home Email Address _____ Home or Mobile Phone Number _____

Work Location _____ Region _____ Work Phone Number _____

Position _____ Normal work hours/schedule: _____

Principal/Program Manager Notification	
☐ I have notified my Principal/Program Manager of my intent to request Emergency Paid Sick Leave (EPSL).	
Supervisor Name	Supervisor's Email and Phone Number

Reason for Leave *(check all applicable):*		
I am unable to work (or telework) for the following reasons:		
1.	☐	I am subject to federal, state, or local quarantine or isolation order related to COVID–19. Name of governmental entity ordering quarantine: _____
2.	☐	I have been advised by a health care provider to self-quarantine due to concerns related to COVID–19. Name of the health care professional advising self-quarantine: _____
3.	☐	I am experiencing symptoms of COVID–19 and seeking a medical diagnosis. Name of the health care provider: _____
4.	☐	I am caring for an individual who is subject to either number 1 or 2 above. Name and relationship to the employee: _____ Name of governmental entity ordering quarantine or name of health care professional advising self-quarantine: _____
5.	☐	I am caring for a child whose school or childcare provider has been closed due to COVID–19. I certify that no other person will be providing care for the child during the period for which I am receiving paid leave.
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.

Child(ren)'s Information
(If additional space is needed, please provide names of children and school/childcare provider on a blank piece of paper submitted with this form.

Name (First, MI, Last) and Age of Child	Name of School or Childcare Provider
Name (First, MI, Last) and Age of Child	Name of School or Childcare Provider
Name (First, MI, Last) and Age of Child	Name of School or Childcare Provider

-continued on reverse side-

Supporting Documentation *(check all applicable):*

To care for myself or another individual due to COVID-19:

If request is for care of another individual, please indicate the relationship between the individual and the requesting employee: _____

☐ Copy of order/letter to quarantine or isolation (from local, state, or federal government) due to COVID–19

☐ Copy of health care professional note/letter documenting quarantine/isolation order due to COVID–19

☐ Other communication (please specify): _____

To care for a child because of school* or childcare provider closures due to COVID-19:

☐ Letter/email from my child's school* or childcare provider

☐ Link (URL) of my child's school* or childcare provider confirming closure: _____

☐ Other communication (please specify): _____

**If all children listed on page 1 attend an FCPS school (or a public school in a local jurisdiction), no documentation is required.*

Option to Use Leave *(check one):*

EPSL provide for portions of pay to be made available. FCPS employees may elect to use available sick balances (or annual leave if available when sick leave is exhausted) to supplement this mandate to allow for 100% of pay where instance of personal illness, quarantine, or caring for an ill family member. The FFCRA's formula for pay under EPSL is as follows:

- 100% pay (up to cap of $511/day and $5,110 total) for the two weeks of EPSL benefit:
  - Available when the employee is unable to work, because the employee is quarantined by either governmental order or their treating healthcare provider and/or experiencing COVID-19 symptoms and seeking medical care (reasons 1, 2, 3 and 6 on page 1).
- 2/3rd pay (up to a daily rate of $200 and $2,000 total) for the two weeks of EPSL benefit:
  - If employee needs to be absent from work duties, because they are caring for those quarantined by either governmental order or their treating healthcare provider and/or experiencing COVID-19 symptoms and seeking medical care OR have childcare needs for children who are at home due to school/childcare closures related to COVID-19 (reasons 4 and 5 on page 1).

☐ **I elect to use available sick leave balances** to supplement the FFCRA EPSL pay allowances.

☐ **I DO NOT elect to use available sick leave balances** to supplement the FFCRA EPSL pay allowances.

Please note: This election is irrevocable. Your election cannot be changed or modified after submission of this form.

I certify that I am requesting leave for a covered reason under the Families First Coronavirus Response Act (FFCRA) and will provide additional documentation to support this leave, if requested by FCPS. I certify there are no other childcare options available to me for the period of my childcare-related leave request. Under FFCRA, leave may be requested April 1, 2020, through December 31, 2020. I acknowledge that I am subject to discipline, up to and including termination of employment, for falsifying my need for paid leave under the FFCRA. The Office of Benefit Services will provide email responses for approval and copy your supervisor as we work through this process with you.

If you, employee has been ill or quarantined, a release from your treating provider to return you to work will be required. We will provide you with a template with the approval of this request.

_____ _____

Employee Signature Date

When complete:	**Scan and email form to:**	DisabilityandLeaves@fcps.edu
	Or fax to:	Disability and Leaves at 571-423-5013
	Or mail to:	Department of Human Resources Office of Benefit Services, Suite 2700 8115 Gatehouse Road Falls Church, VA 22042
	Please understand that mailing your form(s) and supporting documentation during this time may result in processing delays. We encourage you to submit your request electronically.	

_____ _____

Processed by Disability and Leaves, FCPS HR Date