SAN JOAQUIN COUNTY
Greatness grows here.

EMERGENCY PAID SICK LEAVE
And EMERGENCY FMLA REQUEST FORM (COVID-19)

Families First Coronavirus Response Act (FFCRA) provisions applies from April 1, 2020 through December 31, 2020.

Section I: EPSL and E-FMLA FORM (COVID-19)

Name: _____ _____ _____
Employee ID Number (Contact Phone)

Address:_____ _____
(Street) (City, State, Zip)

Department: _____ _____
(Division/Supervisor) (Department Name)

SECTION II: QUALIFYING REASONS FOR EPSL AND E-FMLA

I am requesting EPSL for the following reasons related to COVID-19:

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 medical diagnosis.
4. ☐ I am caring for an individual who is subject to Federal, State, or Local quarantine/isolation order related to COVID-19 or who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
5. ☐ I have a child who is under the age of 18 years of age, whose school or place of care has been closed, or whose child care provider is unavailable due to a COVID-19 emergency declared by either a Federal, State, or Local authority.
6. ☐ I am experiencing another 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.

Type of Leave Request: ☐ Consecutive Leave ☐ Intermittent or Reduced Schedule:
Specify proposed schedule for permitted intermittent leave:
_____

Absence Dates: From: _____ To: _____ TOTAL HOURS: _____
(No intermittent leaves allowed for quarantine, isolation, or symptoms)

SECTION III: QUALIFYING REASON FOR E-FMLA ONLY

Employees who are unable to work due to the need to: (a) care for a son or daughter under 18 years of age if the son or daughter's school or place of care has been closed, or whose child care provider is unavailable, due to COVID-19-related reasons, or (b) care for an adult son or daughter (i.e., one who is 18 years of age or older), who (i) has a mental or physical disability, and (ii) is incapable of self-care because of that disability, when the son or daughter's care provider is unavailable due to COVID-19 related reasons.

1. ☐ I have a child who is under the age of 18 years of age, whose school or place of care has been closed, or whose child care provider is unavailable due to a COVID-19 emergency declared by either a Federal, State, or Local authority.

SECTION IV: PAY OPTIONS:

EPSL PAY:

EMERGENCY PAID SICK LEAVE (EPSL): Employees must use the provided 80-hours (pro-rated amount of hours for part time employees based on average two-week period) EPSL, to the extent such time is available, for the qualifying reasons related to COVID-19. **Exception**: If you are requesting leave related to caring for child who is under the age of 18 years of age, whose school or place of care has been closed, or whose child care provider is unavailable due to a COVID-19 emergency declared by either a Federal, State, or local authority.

For request specifically related to Child(ren)'s School/Childcare Closure refer to E-FMLA PAY OPTIONS BELOW:

E-FMLA PAY OPTIONS ONLY

E-FMLA is a job-protected paid leave at *two-thirds the employee's regular rate of pay* where an employee, who has been employed for at least 30 calendar days, is unable to work due to a bona fide need for leave to care for a child whose school or child care provider is closed or unavailable for reasons related to COVID-19. The paid expanded leave is in addition to EPSL. **SPECIAL NOTE**: The E-FMLA is not in addition to existing 12-week leave entitlement under FMLA. Therefore, if an employee has already used all or a portion of their 12-week entitlement of FMLA leave for another qualifying reason, the employee is only entitled to use the remaining balance for qualifying reasons under E-FMLA.

Please review and elect: 1) paid or unpaid options during the initial two weeks (10 days), and 2) elect to coordinate additional 10 weeks of ***paid expanded family and medical leave*** with EPSL, accrued paid leave or wage replacement benefits to receive your normal bi-weekly rate of pay:

☐ I elect not to use my Emergency Paid Sick Leave and/or accrued paid leave during the initial two weeks of my protected leave of absence under the E-FMLA provision. I understand that during this initial two weeks, I will be in an unpaid status.

☐ I elect to use _____ hours of my Emergency Paid Sick Leave and/or_____ hours of accrued paid leave during my initial two weeks of E-FMLA provision.

☐ I elect to use the following accrued paid leave hours in accordance with the appropriate bargained memorandum of understanding or Board resolution: ☐ Sick leave ☐ Vacation ☐ Holiday ☐ Comp Time ☐ Other_____to receive my normal bi-weekly salary.

☐ I understand that I may be eligible for up to an ***additional 10 weeks of paid expanded family and medical leave*** during which, I request to use _____hours of my Emergency Paid Sick Leave and/or _____hours of accrued paid leave concurrently with *paid expanded family and medical leave*

☐ I understand that I may be eligible for up to an ***additional 10 weeks of paid expanded family and medical leave*** during which, I elect *not* to use Emergency Paid Sick Leave and/or accrued leave **while** receiving a wage replacement benefit to receive my normal bi-weekly salary.

SECTION V: REQUIRED INFORMATION

- If requesting leave for a FEDERAL, STATE OR LOCAL QUARANTINE OR ISOLATION under U.S. Federal, State, or Local Order, please provide the name of the government entity issuing the order:

  _____

  Order Date: _____

- If requesting leave for a HEALTH CARE PROVIDER QUARANTINE OR ISOLATION ORDER/ADVICE, identify the health care provider making the ordered or so advising:

  _____

  Address: _____ City: _____State: _____

  Order/Advice Date: _____

- If requesting leave for COVID-19 SYMPTOMS AND SEEKING DIAGNOSIS identify the health care provider or clinic providing testing or other diagnostic services:

  _____

  Address: _____ City: _____ State: _____

  Order/Advice Date: _____

- If requesting leave to CARE FOR AN INDIVIDUAL SUBJECT TO QUARANTINE/ISOLATION ORDER OR ADVICE provide the name of the government entity or health care provider issuing the order/advice:

  _____

  Order Date: _____

  State the Name of the Individual for whom you are providing care: _____

  State the individual's relationship to you: _____

- If requesting leave for Child(ren)'s School/Childcare Closure/Unavailability provide the name(s) of the child(ren) being cared for:

  _____

  Identify the school, place of care or child care provider closed/unavailable: _____

  Do you certify that no other suitable person is available to care for the child(ren) during the requested leave?

  ☐ YES ☐ NO

- If requesting leave for SELF-ISOLATION DUE TO CONCERN ABOUT EXPOSURE, has a health care provider advised you to isolate for your safety or that of someone in your household? ☐ YES ☐ NO

  If YES, identify the health care provider making the ordered or so advising: _____

  Address: _____ City: _____ State: _____

  Order/Advice Date: _____

SECTION VI:

1. The County must approve my request, and I may be required to meet eligibility requirements and/or submit certification or supporting documentation to be eligible for Emergency Paid Sick Leave and *Emergency Family Medical Leave Act* (E-FMLA).
2. Any leave of absence may be revoked by the Director of Human Resources upon written request of the Department Head supported by evidence that the reason for granting leave was misrepresented or has ceased to exist.
3. I am responsible to pay my share of the premiums to maintain my health benefits coverage and other deductions.
4. My share of health premiums will be paid through payroll deduction whenever I utilize leave accruals to cover the cost of premiums. If I do not have enough hours for the health deduction through payroll, I must arrange payment with the Benefits Unit.
5. If I receive wage-replacement benefits (e.g. SDI, PFL, or Unemployment Benefits related to COVID -19), I may elect to use applicable leaves balances as allowed by policy/MOU/state/federal law in situations where use of accrued leave is not required.
6. I must notify my employer if I receive wage-replacement benefit (SDI, PFL, or Unemployment Benefits related to COVID -19) and understand that I will be responsible for reimbursing the County for monies paid that result in an overpayment.

I have read and understand the above information. I acknowledge that it is my responsibility to communicate with my supervisor regarding my leave status. I understand that if my circumstances change, I must immediately inform my supervisor and coordinate my return to work.

I have attached the supporting documentation to support this request: ☐ Yes ☐ No

Exclusion: Some health care workers and first responders may be excluded from *FFCRA provisions which include Emergency Paid Sick and E-FMLA. Human Resources is working closely with Department Heads to provide guidance as needed.*

I UNDERSTAND THAT LEAVE TAKEN AS A RESULT OF THE COVID-19 PUBLIC HEALTH CRISIS FOR WHICH I RECEIVE PAID LEAVE UNDER THE FFCRA WILL BE COUNTED AGAINST FMLA LEAVE ENTITLEMENTS. I ALSO UNDERSTAND THAT PROVIDING FALSE OR MISLEADING INFORMATION ABOUT MY ABSENCE WILL RESULT IN DISCIPLINARY ACTION, UP TO AND INCLUDING TERMINATION OF MY EMPLOYMENT.

_____ _____

Employee's Signature *Date*

☐ Leave Request Approved ☐ Recommend Denial Reason for Recommending Denial: _____

If the department finds an employee to be ineligible and recommends denial, the department is required to obtain concurrence from Human Resources before notifying the employee.

Signature-Appointing Authority or Designee:	Date

FOR HUMAN RESOURCES DIVISION USE ONLY

Eligible for protected leave insurance coverage from _____ to _____ Protected Leave Ends: _____

(☐) Leave approved as recommended (☐) other: _____ Dates: _____

_____ _____

Authorized Signature Date