HUMAN RESOURCES
Illinois State University

Emergency Paid Sick Leave Request Form

Name: _____ University ID: _____

Address: _____ Contact Ph.: _____

City, State, Zip: _____Work Ph.: _____

Department: _____ Mail Code: _____ Supervisor: _____

Beginning Date for Leave: _____ Estimated Length of Leave: _____

Last Day Worked: _____ Normal Work Schedule (Days & Times): _____

Leave Type: Available for continuous time away from work only

Please mark the covered reason that applies for your request to use Emergency Paid Sick.

☐ (1) The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19.
Provide official documentation, if available, and
Name of the governmental entity ordering quarantine: _____

☐ (2) The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
Provide official documentation, if available, and
Name of the health care provider ordering quarantine: _____

☐ (3) The employee is experiencing symptoms of COVID-19 and is seeking a medical diagnosis.
Provide official documentation, if available, and
Name of the health care provider contacted to seek diagnosis: _____

☐ (4) The employee is caring for an individual who is either:
1) Subject to a Federal, State, or local quarantine or isolation order related to COVID-19, or
2) Has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

Provide official documentation, if available, and Name of the governmental entity or health care provider ordering quarantine: _____

Name of the individual: _____Relationship: _____

☐ (5) The employee unable to work or telework (if employer approved) due to the need to care for:

- The employee's child under the age of 18,
- A child under the age of 18 for whom the employee has legal guardianship,
- A child who has been placed with the employee for foster care,
- The employee's child who is over the age of 18 but requires assistance with activities of daily living as defined by the Americans with Disabilities Act Amendments Act

due to the closure of the child's school or place of care, or if the eligible childcare provider is unavailable because of COVID-19 precautions.

Nelson Smith Building 101 Campus Box 1300 Normal, IL 61790-1300

(309) 438-8311 Fax: (309) 438-7421 Email: hrbenefits@ilstu.edu

Name of Child: _____ Date of birth: _____

Child's School: _____Closure Dates: _____

Eligible Child Care Provider: _____ Dates Unavailable: _____

Provide documentation substantiating the need for leave as required per policy 3.1.48 and complete the additional statements below.

Please complete the statements below for Reason Number 5:

☐ I certify that I am the only individual available during the timeframe of my requested leave who is available to care for the above-named child(ren).

If you are requesting Reason Number 5 to care for a child older than age 14 during daylight hours, please submit your justification of why this child requires your care during those hours.

☐ (6) The employee is 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.

☐ (7) The employee requires time away from work to obtain an immunization related to COVID-19.
Provide proof of immunization, and
Location, date, and time of immunization appointment(s):

☐ (8) The employee is recovering from an injury, disability, illness, or condition related to the COVID-19 immunization.
Provide proof of immunization.

☐ (9) The employee is seeking or awaiting the results of a COVID-19 test or diagnosis because either the employee has been exposed to COVID-19 or the employer has requested such test or diagnosis.
Provide official test or diagnosis results.

Please sign your initials to certify that you have read and understand each section below.

___ I understand that my compensation will be calculated in accordance with policy 3.1.48 Emergency Paid Sick Leave.

___ I understand that I need to provide documentation to substantiate my need for leave. If it is found that I have falsified my need for leave, my leave may be denied and/or I may be subject to disciplinary action up to and including termination

___ I understand that while using Emergency Paid Sick Leave, I will be required to furnish Human Resources with periodic reports of my status and intent to return to work when requested.

___ I understand that when applying for this benefit, I am responsible for following my normal departmental call-in procedural requirements until approval is received.

___ Information and updates regarding your request for Emergency Paid Sick Leave will be provided through your Illinois State University email account (xxxxxx@ilstu.edu). It is your responsibility to ensure that your email is active and remains active while on leave. If you require any assistance with your email notifications, please contact the Technology Support Center at 309-438-HELP (4357).
I have read and initialed each section above.

Applicant's Signature: _____ Date: _____