



## 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.

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.

**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: \_\_\_\_\_