

EMPLOYEE REQUEST FOR EMERGENCY PAID SICK LEAVE OR EMERGENCY FAMILY AND MEDICAL LEAVE FOR COVID-19 (CORONAVIRUS) RELATED REASON AND SELF CERTIFICATION

Employees requesting Emergency Paid Sick Leave and/or Emergency Family and Medical Leave must complete this form, collect proper documentation supporting the need for leave and return both to Human Resources as soon as practicable. Consult the Company's Emergency Paid Sick Leave Policy and Emergency Family and Medical Leave Expansion Act Policy for more information regarding your entitlement to leave. Providing false information or documentation shall constitute a violation of Company policy.

NAME: _____ **Date of Request:** _____

EMERGENCY PAID SICK LEAVE:

_____ I am unable to work or telework because I am subject to a federal, state or local quarantine isolation order related to COVID-19. I attach documentation related to the order.

- Name of government entity issuing order: _____

_____ I am unable to work or telework because I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

- Name of health care provider advising self-quarantine: _____

_____ I am unable to work or telework because I am experiencing COVID-19 symptoms and seeking a medical diagnosis.

- Name of health care provider from whom seeking diagnosis: _____

_____ I am unable to work or telework because I am caring for an individual who is subject to a federal, state or local quarantine or 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. I attach documentation related to the order.

- Name of individual to whom providing care: _____
- Relationship to you of person to whom providing care: _____
- Name of government entity issuing order or health care provider advising self-quarantine: _____

_____ I am unable to work or telework because I am caring for my child whose school or child-care provider is closed/unavailable due to concerns related to COVID-19. I have attached documentation with this request demonstrating that the school or childcare provider is closed/unavailable.

- Name and age of child: _____
- Name of school, place of care, or child care provider: _____
- Will any other suitable person be caring for the child during the period Emergency Paid Leave is requested?? _____
- If the child is older than 14 and needs care during daylight hours, please explain the special circumstances that exist requiring you to provide care during those times: _____

_____ I am unable to work or telework because I am experiencing "any other substantially similar condition" specified by the U.S. Department of Health and Human Services.

LENGTH OF LEAVE: Begin: _____ End: _____

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ELECTION TO USE OTHER AVAILABLE LEAVE: *You may elect to use any existing accrued, paid time off before using Emergency Paid Sick Leave and/or you may use it to supplement your Emergency Paid Sick Leave benefit, to the extent such time is available for the reasons you have identified. Please contact [Human Resources/Payroll] should you wish to utilize other accrued, paid time off. The ability to supplement the EPSL benefit with paid leave is at the Company's discretion.*

EMERGENCY FAMILY AND MEDICAL LEAVE (EFML)

_____ I am unable to work or telework because I am personally caring for my child because my child's school, place of care, or childcare provider is closed/unavailable due to the COVID-19 public health emergency. I attach documentation with this request demonstrating that the school or childcare provider is closed/unavailable.

- Name and age of child: _____
- Name of school, place of care, or child care provider: _____
- Will any other suitable person be caring for the child during the period Emergency Paid Leave is requested?? _____
- If the child is older than 14 and needs care during daylight hours, please explain the special circumstances that exist requiring you to provide care during those times: _____

LENGTH OF LEAVE: Begin: _____ End: _____

ELECTION TO USE OTHER AVAILABLE LEAVE: *The first ten days of EFML requested shall be unpaid. You may elect to use other accrued paid leave (such as Sick/Vacation/Off duty days) the first ten days of leave by electing such below or you may use your Emergency Paid Sick Leave ("EPSL") the first 10 days of your EFML. [OPTIONAL]The Company will require you to use any existing paid time off to supplement the EFML benefit you receive during the 10 weeks of paid EFML.*

_____ I wish to use Sick/Vacation/Off duty days to the following unpaid portion of my EFML _____

_____ I wish to use my EPSL benefit during the unpaid portion of my EFML.

_____ I wish to supplement my EPSL benefit during the first 10 days of my EFML using Sick/Vacation/Off duty days.

IF YOU DID NOT HAVE SUFFICIENT SPACE ABOVE, PLEASE FEEL FREE TO PROVIDE ANY ADDITIONAL RELEVANT INFORMATION IN THE SPACE BELOW

BY SIGNING BELOW, I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER UNDERSTAND THAT ANY FALSE STATEMENT MAY RESULT IN DISCIPLINARY ACTION, UP TO AND INCLUDING TERMINATION OF EMPLOYMENT.

Print Full Name

Signature

Date