CULLMAN COUNTY COMMISSION

EMERGENCY PAID SICK LEAVE REQUEST

Employees requesting Emergency Paid Sick Leave (EMRGNC SK1 and/or EMRGNC SK2) pursuant to the Families First Coronavirus Response Act (FFCRA) must complete this form. You must provide as much advance notice as is reasonably practicable. Upon completion of this form, submit it to Human Resources for processing.

Employee Name:

Employee Home Address: **E-mail:**

Home Phone Number: **Cell Phone Number:**

This is a *(choose one)*: ☐ New request for leave ☐ Request for an extension of leave

Anticipated Begin Date of Leave: **Expected Return to Work Date:**

Reason for Leave (*check all applicable*) I am unable to work (or telework) for the following reasons:

☐ I am subject to state, federal or local quarantine or isolation order related to COVID-19 (EMRGNC SK1)
Name of the government entity issuing the order: ______________________________

☐ I have been advised by a health care professional to self-quarantine due to concerns related to COVID-19 (EMRGNC SK1)
Name of the advising healthcare provider: ______________________________

☐ I have symptoms related to COVID-19 and I am seeking (or have sought) a diagnosis (EMRGNC SK1)

☐ I am caring for an individual who is subject to quarantine or has been advised to quarantine related to COVID-19 (EMRGNC SK2)
Name of the person I am caring for and our relationship: ______________________________
Name of the government entity issuing the order: ______________________________
OR Name of the advising healthcare provider: ______________________________

☐ I need to care for my child (age 17 and under) because the child's school, child care or child care provider is closed or unavailable because of COVID-19 (EMRGNC SK2)
Name(s) and age(s) of child(ren): ______________________________
Name of closed school(s) or place(s) of care: ______________________________

☐ I am experiencing other conditions substantially similar to COVID-19 as specified by HHS. (EMRGNC SK2)

Attach documentation from medical provider or school/child care provider as applicable.

I will need *(choose one)*: ☐ Continuous leave ☐ Intermittent leave

If your need for leave is intermittent, please describe the nature of your intermittent leave:

____

____

I certify that the above information is truthful and understand that misrepresenting my need for leave is grounds for discipline, up to and including termination of employment.

Employee Signature: ______________________________ **Date:** ______________

______________________________ ______________

Human Resources Signature Date