EMERGENCY PAID SICK LEAVE ACT (EPSLA) and EMERGENCY FAMILY MEDICAL LEAVE EXPANSION ACT (EFMLEA) EMPLOYEE REQUEST FORM

The St. Tammany Parish School Board requires all EPSLA and EFMLEA leave requests to be submitted using the present form. Forms must be accompanied by appropriate documentation to support the requested leave. Once you have completed the form, please provide same with substantiating documentation to the Human Resources Department for review and processing.

EMPLOYEE INFORMATION:

Employee Name: _____ Employee Identification Number: _____

Position/Dept: _____ Date of Hire: _____

Leave Start Date: _____ Anticipated Duration of Leave:_____

REASON FOR LEAVE:
Select the reasons for the requested leave. All leave requests require documentation to validate the request for leave.

I hereby certify that I am unable to work because **(check one):**

_____ **1.** I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.
State name of government entity that issued order: _____.
(*Attach copy of the quarantine or isolation order.)*

_____ **2.** I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
State name of health care provider: _____.
(*Attach copy of written recommendation from healthcare provider.)*

_____ **3.** I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.
State name of health care provider: _____.
(*Attach documentation regarding pursuit of diagnosis.)*

_____ **4.** I am caring for an individual who: (a) is subject to a federal, state, or local quarantine or isolation order related to COVID-19; or (b) has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

Name of individual to whom you are providing care:_____.
(*Attach quarantine or isolation order OR written recommendation to quarantine.)*

_____ **5**. I am caring for my child whose school or place of care has been closed or whose child care provider is unavailable for reasons related to COVID-19.
State name(s) and age(s) of child(ren):_____.
State name(s) of school(s) or place(s) of care that has/have been closed or name of care giver/provider who is unable due to COVID-19 precautions:_____.
(*Attach public notice documenting closure or communication from school, childcare facility, or childcare provider*.)

_____(**Initial)** I confirm that no other person will be providing care for my child(ren) during the period for which leave is requested, and that if such child(ren) is/are older than fourteen (14) years of age, special circumstances exist which require that care be provided.

_____ **6.** I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services.
(Attach written recommendation to quarantine.)

ACKNOWLEDGEMENT AND SIGNATURE:

I acknowledge that I have read this request form and have completed it truthfully and accurately to the best of my knowledge and ability. I have attached the required documentation to support my leave request as specified above. My signature below is an acknowledgement that I am unable to work due to the Reason for Leave as indicated on this form.

I further understand and acknowledge that the Human Resources Department will review this request to ensure that the requisite criteria pursuant to applicable law and regulations has been met before the requested leave and/or emergency pay will be approved.

Based on the reason indicated on page 1 of this document I understand that I will be paid as follows:

- 100% of my daily rate of pay for qualifying reasons #1-3, up to $511 daily and $5,110 total (up to 2 weeks total)
- ⅔ of my daily rate of pay for qualifying reasons #4 and 6, up to $200 daily and $2,000 total (up to 2 weeks total)
  - ☐ I choose to use accrued emergency and/or vacation time (if available) to supplement the ⅔ ratio to equate to my regular daily rate of pay.
  - ☐ I choose NOT to use accrued emergency and/or vacation time to supplement the ⅔ ratio to equate to my regular daily rate of pay.
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at ⅔ for qualifying reason #5 for up to $200 daily and $12, 000 total
  - Duration of time requested: _____
  - ☐ I choose to use accrued emergency and/or vacation time (if available) to supplement the ⅔ ratio to equate to my regular daily rate of pay.
  - ☐ I choose NOT to use accrued emergency and/or vacation time to supplement the ⅔ ratio to equate to my regular daily rate of pay.

This form and required documentation must be sent to the Human Resources Department:
Certificated Personnel: steve.alfonso@stpsb.org or (985) 898-3295
Non-Certificated Personnel: lori.niehaus@stpsb.org or (985) 898-3205

_____ _____
Employee Signature **Date**

For Human Resources Only – Do not write below this line

□ Approved **□ Denied**

_____ _____
HR Representative Date

Copy – Employee Copy – HR Department

(LFN/mjdb 6/2020)

EMPLOYEE RIGHTS

PAID SICK LEAVE AND EXPANDED FAMILY AND MEDICAL LEAVE UNDER THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT

The **Families First Coronavirus Response Act (FFCRA or Act)** requires certain employers to provide their employees with paid sick leave and expanded family and medical leave for specified reasons related to COVID-19. These provisions will apply from April 1, 2020 through December 31, 2020.

▸ PAID LEAVE ENTITLEMENTS

Generally, employers covered under the Act must provide employees:

Up to two weeks (80 hours, or a part-time employee's two-week equivalent) of paid sick leave based on the higher of their regular rate of pay, or the applicable state or Federal minimum wage, paid at:

- 100% for qualifying reasons #1-3 below, up to $511 daily and $5,110 total;
- ⅔ for qualifying reasons #4 and 6 below, up to $200 daily and $2,000 total; and
- Up to 12 weeks of paid sick leave and expanded family and medical leave paid at ⅔ for qualifying reason #5 below for up to $200 daily and $12,000 total.

A part-time employee is eligible for leave for the number of hours that the employee is normally scheduled to work over that period.

▸ ELIGIBLE EMPLOYEES

In general, employees of private sector employers with fewer than 500 employees, and certain public sector employers, are eligible for up to two weeks of fully or partially paid sick leave for COVID-19 related reasons (see below). *Employees who have been employed for at least 30 days* prior to their leave request may be eligible for up to an additional 10 weeks of partially paid expanded family and medical leave for reason #5 below.

▸ QUALIFYING REASONS FOR LEAVE RELATED TO COVID-19

An employee is entitled to take leave related to COVID-19 if the employee is unable to work, including unable to **telework**, because the employee:

1. is subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
2. has been advised by a health care provider to self-quarantine related to COVID-19;
3. is experiencing COVID-19 symptoms and is seeking a medical diagnosis;
4. is caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
5. is caring for his or her child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
6. is experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.

▸ ENFORCEMENT

The U.S. Department of Labor's Wage and Hour Division (WHD) has the authority to investigate and enforce compliance with the FFCRA. Employers may not discharge, discipline, or otherwise discriminate against any employee who lawfully takes paid sick leave or expanded family and medical leave under the FFCRA, files a complaint, or institutes a proceeding under or related to this Act. Employers in violation of the provisions of the FFCRA will be subject to penalties and enforcement by WHD.

WAGE AND HOUR DIVISION
UNITED STATES DEPARTMENT OF LABOR

For additional information or to file a complaint:
1-866-487-9243
TTY: 1-877-889-5627
dol.gov/agencies/whd

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