EMERGENCY PAID SICK LEAVE ACT (EPSLA)
REQUEST FOR LEAVE

Please complete and submit this form to Human Resources. Failure to provide the additional information as indicated in section (B) below may result in delaying or denying your request for leave under the Emergency Paid Sick Leave Act ("EPSLA"). Once the Company receives and reviews the information from you, the Company will then inform you whether your leave will be designated as EPSLA leave. For questions about this form or EPSLA leave, please contact Human Resources.

Employee Name: _____

Title/Position: _____

Reports To: _____

Date Form Submitted/Leave Requested: _____

(A) Please identify the reason(s) for leave:

I am unable to work or telework because I:

- ☐ (1) Am subject to a federal, state, or local quarantine or isolation order related to COVID-19
- ☐ (2) Have been advised by a health care provider to self-quarantine due to concerns related to COVID-19
- ☐ (3) Am experiencing symptoms of COVID-19 and seeking a medical diagnosis
- ☐ (4) 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
- ☐ (5) 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
- ☐ (6) Am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services

Note: EPSLA is paid leave for up to two weeks. If you are unable to work (or telework) for reasons due to a COVID-19 circumstance described in (1), (2), or (3) above, you will be paid at your regular rate of pay up to a maximum of $511 per day. If you are unable to work (or telework) for reasons due to a COVID-19 circumstance described in (4), (5), or (6) above, you will be paid at 2/3 your regular rate of pay up to a maximum of $200 per day.

(B) Please provide additional information to support the reason(s) for the leave:

☐ I am unable to work or telework due to the COVID-19 reason(s) indicated above because:

_____
_____
_____

☐ Name of the federal, state, or local governmental entity placing me in quarantine or isolation related to COVID-19: _____
_____

☐ Name, title and address of the health care provider advising me to self-quarantine due to concerns related to COVID-19: _____
_____

☐ Name of the federal, state, or local governmental entity placing the individual for whom I am caring in quarantine or isolation related to COVID-19: _____
_____

The name of the individual for whom I am caring and relation to me: _____
_____

☐ Name, title and address of the health care provider advising the individual for whom I am caring to self-quarantine due to concerns related to COVID-19: _____
_____

The name of the individual for whom I am caring and relation to me: _____
_____

☐ For caring for my child(ren) due to closure of school or place of care, or child care provider unavailability for reasons related to COVID-19:

- Name(s) and ages(s) of the child(ren): _____
  _____
- Name(s) of school(s) or place(s) of care that has been closed or name of care giver provider who is unavailable due to COVID-19 precautions:
  _____
  _____
- 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 older than fourteen, special circumstances exist requiring me to provide care. _____ (initial)

(C) Please provide the dates of the requested leave:

Leave to begin on: _____
Leave to end on: _____

Note: EPSLA leave is only available for use from April 1, 2020, through December 31, 2020, and only for a qualifying reason occurring during that period.

(D) Have you used any EPSLA leave hours while working for any other employer since April 1, 2020? Yes ___ No ___

If yes, please identify the other employer and the number of EPSLA leave hours used with that employer: _____
_____
_____

(E) Are you also requesting leave under the Emergency Family Medical Leave Expansion Act ("EFMLEA") for this requested leave period?[1] Yes ___ No ___

If yes, please complete and submit an EFMLEA leave request form along with this form. Please note that leave under EPLSA and EFMLEA will run concurrently during such period.

(F) Are you requesting intermittent leave? Yes ___ No ___

If yes, please explain the requested intermittent periods of leave. There may be limitations on your ability to use intermittent leave. Applicable limitations will be discussed with you when your request is processed.

_____
_____
_____

Note: The Company will determine whether your requested intermittent EPSLA leave will be allowed.

***

I certify that the information I have provided in this form is accurate. I understand that it is my responsibility to notify Human Resources immediately if there is any change to my leave request above.

_____ _____
Employee signature Date

[1] Note, EFMLEA leave is only available for leave to care for a dependent child whose school or daycare is closed, or whose care provider is unavailable, due to COVID-19, and is also only available for use for a qualifying event from April 1, 2020 through December 31, 2020.

EMERGENCY PAID SICK LEAVE ACT (EPSLA)
NOTICE OF LEAVE DESIGNATION

TO:

FROM:

DATE:

We have reviewed your request for leave under the Emergency Paid Sick Leave Act ("EPSLA") and any supporting information that you provided. We received your most recent information on _____ and decided:

____ Your leave request is approved and all leave taken for this reason will be designated as EPSLA leave. Please see Section I for further information.

____ Additional information is needed to determine if your leave request can be approved. Please see Section II for further information.

____ Your leave request is not approved. Please see Section III for further information.

If you have any questions about this determination, please promptly contact Human Resources.

SECTION I

_____ Your request for EPSLA leave is approved and all leave taken for this reason will be designated as EPSLA leave.

Please notify us as soon as practicable if dates of scheduled leave change or are extended. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement under EPSLA.

Your leave will begin on _____ and end on _____.

☐ Your approved EPSLA leave is not on an intermittent basis.
☐ Your approved EPSLA leave is on an intermittent basis, as follows:

_____
_____
_____

SECTION II

_____ Additional information is needed to determine if your request for EPSLA leave can be approved. The information you have provided is not complete and sufficient to determine whether EPSLA applies to your leave request. You must provide the following information to Human Resources no later than _____, unless it is not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____

_____

_____

SECTION III

_____ Your request for EPSLA leave is not approved for the following reason(s):

- Your stated reason(s) for leave is/are not an eligible reason(s) for EPSLA leave.
- The information you provided does not support your stated reason(s) for leave.
- You have not demonstrated that you are unable to work or telework due to the stated reason(s).
- You have already exhausted your EPSLA leave entitlement.

EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT (EFMLEA)
REQUEST FOR LEAVE

Please complete and submit this form to Human Resources. Failure to provide the additional information as indicated in section (B) below may result in delaying or denying your request for leave under the Emergency Family and Medical Leave Expansion Act ("EFMLEA"). Once the Company receives and reviews the information from you, the Company will then inform you whether your leave will be designated as EFMLEA leave. For questions about this form or EFMLEA, please contact Human Resources.

Employee Name: _____

Title/Position: _____

Reports To: _____

Date Form Submitted/Leave Requested: _____

(A) Please identify the reason(s) for the leave:

I am unable to work or telework because of:

- ☐ Closure of my child's school for reasons related to COVID-19
- ☐ Closure of my child's place of care for reasons related to COVID-19
- ☐ My child's care provider is unavailable for reasons related to COVID-19

(B) Please provide the following information to support the reason(s) for the leave:

- ☐ I am unable to work or telework due to the COVID-19 reason indicated above because:
  _____
  _____
  _____

- ☐ Name(s) and age(s) of the child(ren): _____
  _____
  _____

- ☐ Name(s) of school(s) or place(s) of care that has been closed or name of care giver provider who is unavailable due to COVID-19 precautions: _____
  _____
  _____

- ☐ I confirm that there is no other suitable person to provide care for my child(ren) during the period for which leave is requested, and that if such child(ren) is older than fourteen, special circumstances exist requiring me to provide care. _____ (initial)

(C) Please provide the dates of the requested leave:

Leave to begin on: _____
Leave to end on: _____

Note: EFMLEA leave is only available for use from April 1, 2020, through December 31, 2020, and only for a qualifying reason occurring during that period.

(D) The first two weeks of EFMLEA leave are unpaid unless you request use of some type of paid leave. Please indicate your choice below.

☐ I am also requesting leave under the Emergency Paid Sick Leave Act ("EPSLA") for the reason(s) identified above, which, if approved, will provide pay at 2/3 my regular rate of pay, up to a maximum of $200 per day for up to the first two weeks.

☐ I request to use my available paid time off (e.g., vacation or sick time) under the Company's paid time off policies. If I do not have sufficient paid time off available for the full two weeks, after I have exhausted such paid time off: (choose one)

- ☐ I will take unpaid leave for the remainder of the first two weeks.
- ☐ I will utilize EPSLA leave.

☐ I request to take the EFMLEA leave unpaid for up to the first two weeks.

Note: If you are also requesting to use EPSLA leave during the first two weeks of the EFMLEA leave, please complete and submit an EPSLA leave request form along with this form. Please note that leave under EFMLEA and EPSLA will run concurrently during such period.

Note: After the first two weeks of EFMLEA leave, eligible employee are paid at 2/3 their regular rate of pay up to a maximum of $200 per day for up to 10 weeks of EFMLEA leave.

(E) Are you requesting intermittent leave?: Yes ___ No ___
If yes, please explain the requested intermittent periods of leave under the EFMLEA:
_____
_____
_____

Note: The Company will determine whether your requested intermittent EFMLEA leave will be allowed.

***

I certify that the information I have provided in this form is accurate. I understand that it is my responsibility to notify Human Resources immediately if there is any change to my leave request above.

_____ _____

Employee signature Date

EMERGENCY FAMILY AND MEDICAL LEAVE EXPANSION ACT (EFMLEA)
NOTICE OF LEAVE DESIGNATION

TO:

FROM:

DATE:

We have reviewed your request for leave under the Emergency Family and Medical Leave Expansion Act ("EFMLEA") and any supporting information that you provided. We received your most recent information on _____ and decided:

_____ Your leave request is approved and all leave taken for this reason will be designated as EFMLEA leave. Please see Section I for further information.

_____ Additional information is needed to determine if your leave request can be approved. Please see Section II for further information.

_____ Your leave request is not approved. Please see Section III for further information.

If you have any questions about this determination, please promptly contact Human Resources.

SECTION I

_____ Your request for EFMLEA leave is approved and all leave taken for this reason will be designated as EFMLEA leave.

Please notify us as soon as practicable if dates of scheduled leave change or are extended. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave entitlement under EFMLEA (and FMLA if applicable).

Your leave will begin on _____ and end on _____ ("Approved EFMLEA Leave")

☐ Your approved EFMLEA leave is not on an intermittent basis.
☐ Your approved EFMLEA leave is on an intermittent basis, as follows:

_____
_____
_____

Under FMLA, eligible employees may take up to 12 weeks of leave for a qualifying event in the applicable 12-month period.

☐ According to our records, you are eligible for FMLA leave and you have a remaining FMLA leave balance of _____ as of today, which may be used

for EFMLEA qualifying reason(s) and any other standard FMLA qualifying reasons. Your Approved EFMLEA Leave will count toward the EFMLEA leave as well as FMLA leave entitlement.

☐ According to our records, you are currently not eligible for FMLA Leave. Your Approved EFMLEA Leave will count toward the EFMLEA leave entitlement.

Please be advised, for up to the first two weeks of the approved EFMLEA leave:

☐ You have requested to use paid leave under the Emergency Paid Sick Leave Act ("EPSLA"). Accordingly, you will be paid during such period at 2/3 your regular rate of pay up to $200 per day in accordance with EPSLA. Please note that leave under EFMLEA and EPSLA will run concurrently during such period.

☐ You have requested to use your available paid time off (e.g., vacation or sick time) under the Company's paid time off policies during such period. You currently have sufficient paid time off to cover such period, and will be paid during such period in accordance with the Company's time off policies.

☐ You have requested to use your available paid time off (e.g., vacation or sick time) under the Company's paid time off policies, but if such paid time off is not sufficient to cover such period, then to take paid leave under EPSLA for the remainder of such period. Accordingly, once you have exhausted your available paid time off, the remainder of such period will be paid at 2/3 your regular rate of pay up to $200 per day in accordance with EPSLA. Please note that EFMLEA and EPSLA will run concurrently during the remainder of such period.

☐ You have requested to use your available paid time off (e.g., vacation or sick time) under the Company's paid time off policies, but if such paid time off is not sufficient to cover such period, to take the remainder of such period unpaid. You currently do not have sufficient paid time off available to cover such period. Therefore, once you have exhausted your available paid time off, the remainder of such period will be unpaid.

☐ You have requested that you take the EFMLEA leave unpaid for up to the first two weeks.

Note: After the first two weeks of EFMLEA leave, eligible employee are paid at 2/3 their regular rate of pay up to a maximum of $200 per day for up to 10 weeks of EFMLEA leave.

SECTION II

_____ Additional information is needed to determine if your request for EFMLEA leave can be approved. The information you have provided is not complete and sufficient to determine whether EFMLEA applies to your leave request. You must provide the following information to Human Resources no later than _____, unless it is

not practicable under the particular circumstances despite your diligent good faith efforts, or your leave may be denied.

_____

_____

_____

SECTION III

_____ Your request for EFMLEA leave is not approved for the following reason(s):

- ☐ You have worked for the Company for fewer than 30 calendar days.
- ☐ Your stated reason(s) for leave is/are not an eligible reason(s) for EFMLEA leave.[1]
- ☐ The information you provided does not establish that your child's school or place of care is closed or your child's day care provider is unavailable due to COVID-19 precautions.
- ☐ You have not demonstrated that you are unable to work or telework due to the stated reason(s).
- ☐ You have already exhausted your EFMLEA and/or FMLA leave entitlement in the applicable 12-month period.

[1] You may be eligible for unpaid FMLA leave pursuant to the usual qualifying events, such as your own serious illness or caring for a family member with a serious illness. If you believe you have a usual qualifying event, please submit your request on the Company's standard FMLA form, or seek assistance from Human Resources.