



Application for Federal Families First Coronavirus Response Act – Emergency Paid Sick Leave and Expanded Family Medical Leave

Employee Name	Employee Number	Date Requested
Leave Start Date	Leave End Date	Telephone Number with area code
Employee’s Home Address		Employee Personal Email
<p>If you have already taken and exhausted Emergency Paid Sick Leave (“EPSL”) or Expanded Family Medical Leave (“EFML”) (up to 2 weeks of EPSL and up to 12 weeks of EFML) and/or if you are not otherwise eligible for EPSL or EFML but have a need for COVID-19 emergency leave, please complete and submit an application for the Lee Health Sponsored Emergency Leave of Absence (Form #2233).</p> <p>This application is <u>not for</u> documented exposures at work as these are handled under Lee Health’s Worker’s Compensation process.</p>		

A. Emergency Paid Sick Leave: Employee must check the most appropriate box below indicating the reason for seeking Federal Emergency Paid Sick Leave.

I am unable to work or telework (work remotely) because:

- 1. I am subject to a quarantine or isolation order (federal, state, local) related to COVID-19;
- 2. I have been advised by a health care provider to self-quarantine;
- 3. I am experiencing symptoms of COVID-19 and seeking a medical diagnosis;
- 4. I have a genuine need to care for an individual subject to quarantine or self-isolation order (pursuant to a Federal, State or local government order) or who has been advised by a health care provider to self-quarantine (pursuant to advice of a health care provider).
- 5. I have a genuine need to care for a son or daughter whose school or place of care is closed, or whose child care provider is unavailable, due to COVID-19 precautions **(If you are unable to work due to child care reasons for more than two weeks you may be eligible for Expanded Family Medical leave, and should check box 7 below);** or
- 6. I am experiencing substantially similar conditions as specified by the Department of Health and Human Services.

B. Expanded Family Medical Leave: Employee must check the box below indicating a need for Expanded Family Medical Leave if the need for qualifying child care leave is for a period greater than 2 weeks or if employee has otherwise exhausted the 2 weeks of Emergency Paid Sick Leave.

I am unable to work or telework (work remotely) because:

- 7. I have a genuine need to care for a son or daughter whose school or place of care is closed, or child care provider is unavailable, due to COVID-19.



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Reason for Leave	Required Documentation
1. You are subject to a Federal, State, or local quarantine or isolation order related to COVID-19	If you are subject to an order specific to you, please provide that order.
2. You have been advised by a health care provider to self-quarantine related to COVID-19	Note from your health care provide indicating you need to stay home, you do not need to provide a diagnosis or reason why you need to stay home.
3. You are experiencing COVID-19 symptoms and are seeking a medical diagnosis	Employee must provide information identifying his or her symptoms and a date for a test or health care provider’s appointment.
4. You have a genuine need to care for an individual subject to a quarantine order or who has been advised to self-quarantine by a health care provider	Provide the order applicable to the person or a note from the individual’s health care provider indicating that they have been advised to self-quarantine and that they require your care.
5. You have a genuine need to care for your child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons	Notice of closure or unavailability from your child’s school, place of care, or child care provider, which may include a notice that may have been posted on a government, school, or day care website, published in a newspaper, or emailed to you from an employee or official of the school, place of care, or child care provider.
6. You are experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services	

Employee Attestation

I hereby verify that the qualifying reason I selected above applies to me and that my representations in this Application are truthful. I understand that Human Resources will review my Application and determine my eligibility to participate in one or more of the Families First Coronavirus Response Act leave programs. I have provided my current contact information on this form. I further acknowledge this Application does not constitute a contract of employment and that my employment remains at-will.

Employee Signature:	Date:
Department Head Signature:	Date:

Return this Completed Form and relevant documentation to the HR Call Center – Fax: 239-424-4082. or e-mail to employeeservicecenter@leehealth.org. Give a copy to your Supervisor prior to the requested leave start date.