PNGISD Leave Request Form:
Emergency Paid Sick Leave and Expanded Family Medical Leave

Name	**Employee ID**
Department/Campus	**Position**
Email	**Phone number**
Date	**Duration of Leave** *(specify dates requested)*

Leave benefits under the Families First Coronavirus Response Act (FFCRA) apply for the limited time period of April 1, 2020 to December 31, 2020. The amount of paid leave an employee may receive will vary depending on the reason leave is taken. Detailed information is available in the Employee Rights notice that can be found at www.pngisd.org on the Home Page under Coronovirus Info.

An employee requesting emergency paid sick leave and expanded family and medical leave must complete this form and return it to Tracy Reinholt at treinholt@pngisd.org as soon as the need for leave is identified. Documentation supporting the need for leave should be included when the request is submitted.

Emergency Paid Sick Leave (EPSL) is limited to 80 hours of paid leave at the following rates:

- Self: regular rate of pay up to $511 per day
- For care of an individual or a child: two-thirds the regular rate of pay up to $200 per day

Expanded Family and Medical Leave (EFML) provides up to twelve weeks of leave to care for a son or daughter when school is closed or child care is unavailable due to COVID-19. The first two weeks are unpaid, although the empoyee may access EPSL or other paid leave during this time. The remaining 10 weeks is two-thirds the regular rate of pay up to $200 per day.

I request leave for the following reason(s):

Self (Eligible for EPSL and Unpaid FMLA*)

____ I'm subject to a federal, state, or local quarantine or isolation order related to COVID-19.

Name of entity requiring quarantine or isolation: _____

____ I've been advised to self-quarantine by a health care provider.

Name of health care provider requiring quarantine or isolation: _____
**Please enclose supporting medical documentation

____ I'm experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

Name of health care provider: _____
**Please enclose supporting medical documentation

____ I'm expericing any other substantially-similar conditions specified by the U.S. Department of Health and Human Services.

Identify symptoms: _____
**Please enclose supporting medical documentation

Care for other individual (Eligible for EPSL and Unpaid FMLA*)

____ I'm unable to work in order to care for an individual subject or advised to quarantine or isolate.

Name of individual: _____ Relationship: _____

**Please enclose supporting medical documentation.

Care for child (Eligible for EPSL and Reduced Pay EFML)

____ I'm unable to work in order to care for my son or daughter because their school is closed or child care is not available due to COVID-19.

Name of school or child care facility: _____

Are you the only adult caring for the child(ren): _____yes _____no

Name and age of child(ren): _____

If child is over the age of 14 describe special circumstance requiring the care:

_____

Days and times you are responsible for the child(ren)'s care:_____

_____

❑ I attest that no other suitable person is available to care for my child/children during the requested period of leave.

**Please submit documentation from the school or child care providor to support your need for this leave.

*Should you require more than 80 hours of EPSL leave, you must qualify for some other form of leave in accordance with Board Policy. Eligibility for EPSL and EFML does not automatically provide eligibility for standard Family Medical Leave, which should be applied for seperately.

Accrued leave use

I choose to use:

____ EPSL during this absence

____ My accrued paid leave for ____ days during this absence

____ Accured paid leave to "top off" the 2/3 pay covered by EPSL or EFML so I receive 100 percent of my regular rate of pay

Designation *(completed by HR Department)***:**

_____The employee qualifies for EPSL.

_____The employee does not qualify for EPSL.

_____The employee qualifies for _____ weeks of EFML.

_____The employee does not qualify for EFML.

For office use only:

Date of Employment _____

Medical certification provided _____Yes _____ No

Approved by:_____ Date:_____

name and title