DIVISION OF HUMAN RESOURCES
LEAVE ADMINISTRATION

EMERGENCY PAID SICK/
EXPANDED FAMILY AND MEDICAL
REQUEST FOR COVID-19-RELATED LEAVE

Effective for requests made on or after April 1, 2020 through December 31, 2020

Effective April 1, 2020, ***The Families First Coronavirus Response Act (FFCRA***) provides employees with access to Emergency Paid Sick Leave (EPSL) and Expanded Family Medical Leave (EFML) for reasons related to COVID-19. The paid leave provisions are for leave taken for the period of April 1, 2020, to December 31, 2020, and are not retroactive beyond April 1, 2020.

Emergency Paid Sick Leave **(EPSL)** provides up to 80 hours of emergency paid sick leave for qualifying full-time employees that are unable to work (or telework) due to qualifying reasons related to COVID-19. Part-time employees with benefits are eligible to be paid in an amount equal to the number of hours he/she works, on average, over a 2-week period.

Qualifying Reasons

1) I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.
2) I have been advised by a health care provider to self-quarantine because of COVID-19.
3) I am experiencing symptoms of COVID-19 and will be seeking a medical diagnosis.
4) I am caring for an individual who is subject to a quarantine or isolation order or has been advised to self-quarantine related due to COVID-19.
5) I am caring for my son or daughter under 18 years of age whose school or place of care is closed, or the child care provider of such son or daughter is unavailable due to COVID–19 precautions; **THIS REASON QUALIFIES FOR EFML, AND LEAVE TIME WILL BE APPLIED TO THE EMPLOYEE'S FMLA ALLOTTED HOURS.**
6) I am experiencing another substantially similar condition specified by the Secretary of Health & Human Services.

Calculation Used for EPSL:

- For leave reasons (1), (2), or (3): employees taking leave are entitled to pay at either their regular rate or the applicable minimum wage, whichever is higher, up to $511 per day and $5,110 in the aggregate (over a 2-week period).
- For leave reasons (4), (5) or (6): employees taking leave are entitled to pay at 2/3 their regular rate or 2/3 the applicable minimum wage, whichever is higher, up to $200 per day and $2,000 in the aggregate (over a 2-week period).

Expanded Family Medical Leave **(EFML)** allows a qualifying employee to take a leave of absence upto 12 weeks based on caring for a son or daughter under 18 years of age whose school or place of care is closed, or the provider is unavailable due to COVID-19 precautions.

Calculation Used for EFML:

- For leave reason (5): employees taking leave are entitled to pay at 2/3 their regular rate or 2/3 the applicable minimum wage, whichever is higher, up to $200 per day and $12,000 in the aggregate (over a 10-week period)

Do not report to a worksite if you are diagnosed with COVID-19, exhibit symptoms of COVID-19, or in direct contact (within six feet) of an individual with a confirmed case of COVID-19. Notify your supervisor and Human Resources, Leave Administration (leaves@dekalbschoolsga.org***), immediately. Do Not Report to Worksite until cleared by Human Resources, Leave Administration. Acceptable clearance documents are a healthcare provider statement or a negative COVID-19 test result.***

NOTE: Employee must complete pages 1 & 2 of the request form in its entirety.

Please return application to Human Resources, Leave Administration via leaves@dekalbschoolsga.org or fax (678-875-5200).

EMPLOYEE EPSL/EFMLA REQUEST FORM

Instructions to Request EPSL or EFML:

- Complete the two-page application in its entirety. Failure to do so will deem your application as invalid.
- Submit with your application any supporting documentation from your health care provider, if applicable.
- Notify your supervisor as soon as possible regarding your request.
- Submit your application and supporting documents to the Division of Human Resources, Leave Administration, via leaves@dekalbschoolsga.org or fax (678-875-5200).

Date:		**Employee ID**:	
Employee Name ***(please print)***:			
Employee Title/Position		**School/ Department**	
Employee's Supervisor:		**Name of Bookkeeper**:	
Date(s) of Leave Requested:	**Start Date**		**Return Date**

I am requesting EPSL due to my inability to work (or telework) because of the following reason(s):

- ❑ 1) I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.
- ❑ 2) I have been advised by a health care provider to self-quarantine because of COVID-19.
- ❑ 3) I am experiencing symptoms of COVID-19 and will be seeking a medical diagnosis.
- ❑ 4) I am caring for an individual who is subject to a quarantine or isolation order or has been advised to self-quarantine related due to COVID-19.
- ❑ 5) I am caring my son or daughter under 18 years of age whose school or place of care of the son or daughter is closed, or the child care provider of such son or daughter is unavailable due to COVID–19 precautions; **THIS REASON QUALIFIES FOR EFML AND LEAVE TIME WILL BE APPLIED TO THE EMPLOYEE'S FMLA ALLOTTED HOURS.**
- ❑ 6) I am experiencing another substantially similar condition specified by the Secretary of Health & Human Services.

- ❑ I acknowledge that I will receive 2/3 of my pay during the first 80 hours of the Emergency Paid Sick Leave for reasons (4), (5) & (6) **– OR –**
- ❑ I authorize the District to use my ☐ sick, ☐ personal and/or ☐ vacation (if applicable) accrued leave during the first 80 hours of EPSL and when using EFML.

Employee Signature:_____ **Date**:_____

NOTE: Employee must complete pages 1 and 2 of the request form in its entirety.

Please return application to Human Resources, Leave Administration via leaves@dekalbschoolsga.org or fax (678-875-5200).

EMPLOYEE STATEMENT SUPPORTING LEAVE REQUEST:

Please provide information or documentation to support your request for emergency paid sick leave as follows. Complete the section as it applies to your specific reason for leave.

- **Leave due to a government-issued quarantine or isolation order**:

Name of the issuing government agency for the quarantine or isolation order:

_____

- **Leave due to illness OR a health care provider's advice to self-quarantine**:

Name of the health care provider advising me to self-quarantine:

_____

Written documentation is available: ☐ Yes (submit documentation with application) ☐ No

- **Leave to care for an individual who is subject to a quarantine or isolation order or has been advised to self-quarantine**:

Name and relationship of the individual who I must care for:

Name: _____ Relationship: _____

- **Leave due to a school or place of childcare closed due to COVID-19**:

Name, phone number, and address of school or place of care:

_____

_____

Name and age(s) of child or children I must care for:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

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

I attest that the above information is accurate and complete to the best of my knowledge.

Employee Signature: _____ **Date**: _____

NOTE: Employee must complete pages 1 and 2 of the request form in its entirety.

Please return application to Human Resources, Leave Administration via leaves@dekalbschoolsga.org or fax (678-875-5200).