City of Lawrence

EMERGENCY PAID SICK LEAVE (EPSL) AND EMERGENCY FMLA (EFMLA) REQUEST FORM

Employee Name	Employee ID Number	Date
Title	**Supervisor**	**Department (Use Drop-Down)**
		City Attorney's Office
Leave Start Date(s)	**Leave End Date(s)**	**Total Hours Requested**

I CERTIFY THAT AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASON:

☐ **1)** I am subject to a **federal, state, or local COVID-19 quarantine or isolation** order that prevents me from working.
Name of government entity issuing the order:_____

☐ **2)** I have been **advised by a health care provider to self-quarantine** because of concerns related to COVID-19.
Name of the advising healthcare provider:_____

☐ **3)** I have **symptoms of COVID-19** and I am seeking (or have sought) a diagnosis.

☐ **4)** I am **caring for another individual** who is unable to care for themselves and subject to COVID-19 related quarantine, or has been advised by a health care provider to self-quarantine.
Name of person I am caring for:_____ Relationship:_____
Name of the government entity issuing the order: _____
OR Name of the advising healthcare provider:_____

☐ **5) I need to care for my child(ren)** because their school or childcare provider is closed/unavailable or virtual.
I certify that no other suitable person is available to care for the child(ren) during the period of requested leave.
☐ School is open; virtual option chosen (#9 in Executime) Dates: _____
☐ School is closed; virtual option only (#5 in Executime) Dates: _____
If listed child is over 14, I certify that there are **special circumstances** that require me to provide care for them.
Name(s) and age(s) of child(ren): _____
Name of closed school(s) or place(s) of care:_____
Special Accommodations? (Y/N): No
Please Explain:
_____

☐ **6)** I am experiencing **other conditions substantially similar** to COVID-19 as specified by the Department of Health and Human Services. List all related conditions experienced:_____

☐ **7)** I am **at risk for serious illness from COVID-19**, as defined by the Centers for Disease Control (CDC) and have documentation from my healthcare provider. **(Full-time or Part-time Benefited Positions Only)**

☐ **8)** I am **unable to work due to the City closing my work area** AND unable to work remotely/telework.
(Full-time or Part-time Benefited Positions Only)

I certify that the above information is truthful and understand that misrepresenting my need for leave is grounds for initiating the disciplinary action process.

Employee Signature: _____

*If signing electronically, use digital signature or type your full name, followed by "e-signed."

Submit completed forms to FMLA@lawrenceks.org

Send to HR