

III. EMERGENCY PAID SICK LEAVE (EPSL) REQUEST FORM
EFFECTIVE: April 1, 2020 through December 31, 2020
University of California

EMPLOYEE INFORMATION		
EMPLOYEE NAME	EMPLOYEE ID	JOB TITLE
REQUESTED EPSL DATES ENTER BOTH START AND END DATES	EPSL START DATE	EPSL END DATE
LOCATION	DEPARTMENT	SUPERVISOR
REASON FOR TAKING EMERGENCY PAID SICK LEAVE (EPSL)		
I am unable to work or <i>telework</i> during the above period due to the following Reason (as listed in Section I.A above): ___1 ___2 ___3 ___4 ___5 ___6		
COMPLETE SECTION BELOW THAT IS APPLICABLE TO THE REASON FOR WHICH YOU ARE REQUESTING EPSL		
If requesting EPSL for Reason 1: I am unable to work or <i>telework</i> because I am subject to a federal, state, or local <i>quarantine or isolation order</i> related to COVID-19. The following federal, state, or local governmental entity issued this order: _____		
If requesting EPSL for Reason 2: I am unable to work or <i>telework</i> because I have been advised by a <i>health care provider</i> to self-quarantine due to concerns related to COVID-19. The name of that <i>health care provider</i> is: _____		
If requesting EPSL for Reason 3: I am unable to work or <i>telework</i> because I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis from a <i>health care provider</i> . Check here to confirm: ____		
If requesting EPSL for Reason 4: I am unable to work or <i>telework</i> because I am caring for an <i>individual</i> who is either subject to a federal, state, or local <i>quarantine or isolation order</i> related to COVID-19 or who has been advised by a <i>health care provider</i> to self-quarantine due to concerns related to COVID-19. <ol style="list-style-type: none"> Name of <i>individual</i> for whom I am caring: _____ My relationship to this individual is: _____ Complete one of the following: <ol style="list-style-type: none"> The <i>individual</i> identified above is subject to a <i>quarantine or isolation order</i> issued by the following federal, state, or local governmental entity: _____ Name of the <i>health care provider</i> who advised the <i>individual</i> identified above to self-quarantine: _____ 		

If requesting EPSL for Reason 5:

Note: If you are taking EPSL for this reason, your EPSL will run concurrently with your first 2 workweeks of EFML (which would otherwise be unpaid), provided you are eligible for EFML and have EFML entitlement remaining.

I am unable to work or *telework* because I am caring for my *child/children* whose school or place of care has closed (or whose *child care provider* is unavailable) due to COVID-19 precautions.

1. Name and age of each *child* for whom I providing care during the period for which I am requesting EPSL:

2. There is no other suitable person besides me who will be caring for my *child/children* listed above during the period for which I am requesting EPSL. Check here to confirm: ____

3. The name of each *school* or *place of care* that is closed if that is the reason I am providing care for my *child/children* listed above:

4. The name of each *childcare provider* that is closed/unavailable if that is the reason I am providing care for my *child/children* listed above:

5. If I have listed a *child* above who is older than 14 and I am providing care for that *child* during daylight hours, I am required to do that because of the following special circumstances:

6. If I have listed a *child* above who is 18 years or older, that *child* is incapable of self-care because of a mental or physical disability. Check here to confirm, if applicable: ____

If requesting EPSL for Reason 6:

I am unable to work or *telework* because I am experiencing any other substantially-similar condition(s) specified by the U.S. Department of Health and Human Services. Check here to confirm: ____

EMPLOYEE CERTIFICATION

I certify that the foregoing is true. I understand that the University may require additional documentation in support of my request for EPSL.

EMPLOYEE SIGNATURE

DATE