### III. EMERGENCY PAID SICK LEAVE (EPSL) REQUEST FORM

**EFFECTIVE:** April 1, 2020 through December 31, 2020

**University of California**

#### EMPLOYEE INFORMATION

<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>EMPLOYEE ID</th>
<th>JOB TITLE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>REQUESTED EPSL DATES</th>
<th>EPSL START DATE</th>
<th>EPSL END DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENTER BOTH START AND END DATES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>DEPARTMENT</th>
<th>SUPERVISOR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### REASON FOR TAKING EMERGENCY PAID SICK LEAVE (EPSL)

I am unable to work or *telework* 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 *telework* because I am subject to a federal, state, or local *quarantine or isolation order* 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 *telework* because I have been advised by a *health care provider* to self-quarantine due to concerns related to COVID-19.

The name of that *health care provider* is: ________________________________________________________

**If requesting EPSL for Reason 3:**

I am unable to work or *telework* because I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis from a *health care provider*.

Check here to confirm: [ ]

**If requesting EPSL for Reason 4:**

I am unable to work or *telework* because I am caring for an *individual* who is either subject to a federal, state, or local *quarantine or isolation order* related to COVID-19 or who has been advised by a *health care provider* to self-quarantine due to concerns related to COVID-19.

1. Name of *individual* for whom I am caring: _____________________________________________

2. My relationship to this individual is: _____________________________________________

3. Complete one of the following:
   a. The *individual* identified above is subject to a *quarantine or isolation order* issued by the following federal, state, or local governmental entity:

   ____________________________________________________________________________

   b. Name of the *health care provider* who advised the *individual* identified above to self-quarantine:

   ____________________________________________________________________________

**ENTER BOTH START AND END DATES**
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