## EMERGENCY PAID SICK LEAVE (EPSL) REQUEST FORM

IN ACCORDANCE WITH THE TERMS OF THE FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA)

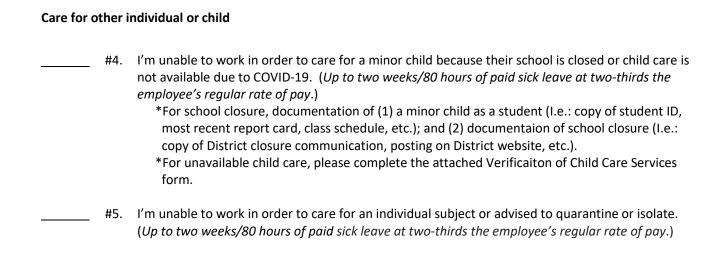
Name	Employee ID
Department/campus	Position
Email	Phone number
First Day of Absence:	Last Day of Absence:
//	/
MONTH DAY YEAR	MONTH DAY YEAR
extended through the end of June 30, 2 on the reason leave is taken. Detailed	nefits under the Families First Coronavirus Response Act (FFCRA) have beer 021. The amount of paid sick leave an employee may receive will vary depending information is available in the FFCRA Employee Rights that can be found under Act in the Quick Links section on the Human Resources page of the Katy ISE
An employee requesting paid sick leave <a href="FFCRA@katyisd.org">FFCRA@katyisd.org</a> .	e for qualifying COVID-19 related reasons must complete this form and email it to
to work because the employee i	aid sick leave at the employee's regular rate of pay where the employee is unable quarantined (pursuant to Federal, State, or local government order or advice o experiencing COVID-19 symptoms and seeking a medical diagnosis; or
employee is unable to work becato Federal, State, or local govers	paid sick leave at two-thirds the employee's regular rate of pay because the nuse of a bona fide need to care for an individual subject to quarantine (pursuantiment order or advice of a health care provider), or to care for a child (under 18 ild care provider is closed or unavailable for reasons related to COVID-19.
	f paid leave at the following rates: 1-3 below, up to \$511 per day ons #4-5 below, up to \$200 per day
I request leave for the following reason	n(s):
Self	
#1. I'm subject to a feder two weeks/80 hours o	al, state, or local quarantine or isolation order related to COVID-19. ( <i>Up to f paid sick leave.</i> )
#2. I've been advised to self-quarantine by a health care provider. ( <i>Up to two weeks/80 hours of paid sick leave.</i> )	

#3. I'm experiencing symptoms of COVID-19 and am seeking a medical diagnosis. (Up to two

weeks/80 hours of paid sick leave.)

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This form should be emailed directly to FFCRA@katyisd.org.

\*\*\*IMPORTANT REMINDER\*\*\*

The date you may return to work is not determined by the number of paid sick leave days you receive.

You may return to work once you have met the criteria outlined in the District Mitigation Plan.

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## **VERIFICATION OF CHILD CARE SERVICES**

To be completed by Owner/Operator of Child Care Facility: Facility Name: Texas Child Care Lisence (CCL) Number: **Operation Status:** (Date) Operational, but currently closed through \_\_\_\_\_ Operational with limitations. Explain: \_\_\_\_\_\_ No longer operational as of \_\_\_\_\_(Date) \_\_\_\_\_is currently enrolled in our child care program. Child's name I certified that the information provided above is accurate and truthful. Signature Date