JONESBORO PUBLIC SCHOOLS
COVID-19 Paid Sick Leave Request Form
(this form must be submitted in its original form - no camera photos accepted)

Employee Name:_____ Date:_____

Building/Location:_____

I request emergency paid sick leave. I am unable to work (or telework) and hereby affirm the following (check all that apply):

_____ 1. I am subject to a federal, state or local quarantine or isolation related to COVID-19. *Provide the name of the government entity that issued the quarantine or isolation order to which you are subject*:_____.

_____ 2. I have been advised by a healthcare provider to self-quarantine due to concerns related to COVID-19. *Provide the name of the health care provider who advised you to self-quarantine for COVID-19 related reasons:*_____.

_____ 3. I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis. *If possible, provide current medical documentation from a medical provider to support this reason.*

_____

_____ 4. I am caring for an individual who is subject to a federal, state or local quarantine or isolation or who has been advised by a healthcare provider to self-quarantine related to COVID-19. *Provide either:*

The name of the government entity that issued the quarantine or isolation order to which the individual being cared for is subject -or-
The name of the health care provider who advised the individual being cared for to self-quarantine due to concerns related to COVID-19:

_____.

_____ 5. I am caring for a son or daughter under 18 years old because the school or place of care has been closed or the care provider is unavailable due to COVID-19. *Provide the following*:

*The name of the son or daughter being cared for:*_____

The name of the school, place of care, or child care provider that has closed or become unavailable:

_____.
*I represent that no other suitable person will be caring for the son or daughter during the period for which I seek to take this leave (enter your initials on the following blank):*_____.

Please check funding that you would like to use first:

☐ State of Arkansas Cares Act Funding (State recommended). Only available for 1, 2 and 3.
☐ Federal Cares Act Paid Sick Leave Funding

I understand the following:

- If the leave is for Reasons 1, 2, or 3, leave will be paid at the greater of my regular rate of pay or the applicable minimum wage. Compensation will not exceed $511 per day.
- If the leave is for Reasons 4 or 5, leave will be paid at two-thirds or the greater of my regular rate of pay or applicable minimum wage. Compensation will not exceed $200 per day.
- Full-time employees are entitled to up to 80 hours of leave from the State of Arkansas Cares Response and 80 hours from the Federal Paid Sick Leave provided in the Cares Act.
- Part-time employees are entitled to both State and Federal Paid Sick Leave if appropriate based on l the number of hours the employee is scheduled to work during an average 2 week time period.

For Part-time employees, unable to work remotely, *supervisors need to complete the hours scheduled during the time period of requested sick leave pay*:

	Hours Scheduled during Absence	**Dates Absent**
Week 1:	_____	_____
Week 2:	_____	_____
Week 3:	_____	_____
Week 4:	_____	_____

Supervisor Signature_____**Date**_____

- **Appropriate documentation must be submitted** before COVID-19 Paid Sick Leave is approved. Examples include but are not limited to: a copy of quarantine or isolation order, written documentation by a healthcare provider, notice of school/day care closing via website, newspaper, email etc.

I affirm that the information provided by me on this form is true, accurate, and current to the best of my knowledge and belief. I affirm that I am unable to work because of the qualifying reason(s) for leave above. I understand that any material misrepresentation of fact made by me as part of this request for leave could result in adverse employment action, up to and including termination of employment.

Date requested for leave to begin: ___/___/___ Anticipated return to work date:___/___/___

Employee Signature:_____ Date:_____

(For Office Use Only)

The request for EPSLA is:

_____ Approved

_____ Denied

_____ The request does not meet the criteria of EPSLA.

_____ Other:_____

_____ _____

Human Resource Manager Date

Revised 9/15/2020