

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	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): <u> 1 2 3 4 5 6</u>		
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: <hr/>		
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. 1. Name of <i>individual</i> for whom I am caring: _____ 2. My relationship to this individual is: _____ 3. Complete one of the following: a. 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: <hr/> b. Name of the <i>health care provider</i> who advised the <i>individual</i> identified above to self-quarantine: <hr/>		

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. During the period for which I am requesting EPSL, my *child's/children's school*, *place of care*, or *child care provider* will be closed or unavailable to my *child/children* only on certain days due to their implementation of an alternate day or other hybrid-attendance schedule.

_____ No, this does not apply to me.

_____ Yes, I confirm this is true. My *child's/children's school*, *place of care*, or *child care provider* will be closed or unavailable to my *child/children* only on certain days because they are implementing the following alternate day or other hybrid-attendance schedule:

For example: “My child’s school only permits my child to attend school in person on Tuesdays and Thursdays, and my child participates in remote learning on Mondays, Wednesdays, and Fridays.”

6. 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:

7. 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: _____

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	SUPERVISOR SIGNATURE	DATE