



COVID-19 Emergency Paid Leave Request Form

Section I. PERSONAL INFORMATION

EMPLOYEE NAME (LAST/FIRST/M.I.) _____		Employee ID: _____
Department _____	Hire Date: _____	Best contact phone number: _____
Employment Status: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> Other: _____		Email: _____
Hours per week: _____		

Section II. EMERGENCY PAID SICK LEAVE (EPSL)

Up to 2 weeks (75/80 hours for Full time and pro-rated for part time)

I am scheduled but unable to work or telecommute for the following qualifying reason(s):

1. I am subject to a federal, state, or local quarantine or isolation order related to COVID-19
 Name of the government entity that issued the order: _____

2. I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19
 Name of the healthcare provider who advised that you self-quarantine: _____

3. I am experiencing symptoms of COVID-19 and seeking a medical diagnosis
No additional documentation needed

4. I am "caring for" an individual who is subject to an order as described in (1) or self-quarantine as described in (2)
 Name of the individual for whom you are caring: _____
 Your relationship to this individual: _____
 Name of the government entity or healthcare provider that required the quarantine: _____

5. I am "caring for" my child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons;
 Name and ages of your children: _____
 Name of school(s), care center(s) and/or care provider(s) that have physically closed or are unavailable due to COVID-19 related reasons: _____

6. I am experiencing another substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

7. I am subject to a CBJ Internal Operations Guidance reason
 Explain: _____

Section III. EMERGENCY FAMILY & MEDICAL LEAVE ACT (EFMLA)

When an employee is unable to work *or telecommute* due to the need to care for their child under 18 years old as a result of a school or child care closure related to COVID-19 related reasons.

Are you considered a "first responder" as defined in the CBJ FAQ? Yes No

If yes, Department Director approval: _____

1. I am scheduled but unable to work *or telecommute* due to the need to care for my child because my child's school or paid child care provider is unavailable due to COVID-19. Yes No

2. I have been employed by the CBJ for at least 30 calendar days. Yes No

3. I have an available balance in my FMLA entitlement to cover the period of requested leave (see LV-FMLA in the accruals tab of your timecard). Yes No Unknown

Request must include documentation of the school or daycare closure. Examples: notice that has been posted on a government, school, or day care website, or published in a newspaper, or an email from an employee or official of the school, place of care, or child care provided.

Section IV. Absence Dates & Pay Request

Absence Dates: _____ to _____ Total hours: _____

Complete proposed schedule for permitted intermittent leaves:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

First 2 weeks (up to 80 hours, subject to pay caps) paid per your selection below:

Unpaid (LWOP) **OR** Paid as follows:

Emergency Paid Sick Leave (EPSL);
Reasons #1-#3 & #7 paid at 100% of your regular rate of pay up to \$511/day and \$5,110 total
Reasons #4-6 paid at 66.6% of your regular rate of pay up to \$200/day and \$2,000 total*

Personal; Comp Time Time; or Donated Leave (separate process required)

Additional 10 weeks (up to 400 hours, subject to pay caps) paid as follows:

Emergency FMLA (EPFML) *paid at 66.6% of your regular rate of pay* up to \$200/day and \$10,000 total*

**If the leave I am requesting is paid at a reduced rate, I am requesting to cash out leave to make up the difference between the reduced rate of leave and my regular rate of pay. Yes No (Payroll will contact you to confirm leave usage)*

Section V. ACKNOWLEDGMENT, SIGNATURE AND APPROVAL

I agree that if my eligibility conditions change, I will notify my employer and my eligibility for leave under these Acts may change. Any misrepresentations provided as a basis for this request will be a basis for disciplinary action.

For Reason #5: By signing this form you certify that no other person will be providing care for the child(ren) during the period for which you are receiving the leave and that for any child(ren) ages 14-17, you have a special circumstance(s) requiring you to provide care during daylight hours.

I acknowledge that any EMFLA leave I request prior to April 1, 2020 will count towards the total EFMLA available under Act.

I declare under penalty of perjury under the laws of the State of Alaska the above is true and correct.

Signed: _____ Date: _____

Print Name: _____

Other relevant information: _____

Please scan completed form to: Payroll.Office@juneau.org

Payroll/HRRM use only:		
<input type="checkbox"/> Approved	<input type="checkbox"/> Denied, Reason: _____	Date
	By/Title	