EMPLOYER SERVICES
A division of Morgan White Group

ARPA Emergency Paid Sick Leave
Emergency Family & Medical Leave

Employee Name _____

Type of leave requested:
☐ Emergency Paid Sick Leave (up to 10 days) ☐ Emergency Family & Medical Leave (up to 12 weeks)

Date or dates for which leave is requested _____

The COVID-19 related reason for requesting leave (check a box below):
☐ 1. Is subject to a Federal, State or local quarantine or isolation order related to COVID-19
☐ 2. Has been advised by a health care provider to self-quarantine related to COVID-19
☐ 3. Is experiencing COVID-19 symptoms and is seeking a medical diagnosis or is awaiting the results of a COVID diagnosis or test after having close contact with a person with COVID-19 or at the employer's request.
☐ 4. Is caring for an individual subject to an order described in (1) or self-quarantine as described in (2)
☐ 5. Is caring for his or her child whose school or place of care is closed (or child-care provider is unavailable) due to COVID-19 related reasons
☐ 6. Is experiencing any other substantially similar condition specified by the U.S. Department of Health and Human Services
☐ 7. Receiving a COVID-19 vaccine or recovering from adverse reactions to the vaccine.

In the case of a leave request based on a quarantine order, name the governmental entity ordering the quarantine:
_____
In the case of a leave request based on self-quarantine advice, name the health care professional advising the self-quarantine: _____
If the person subject to quarantine or advised to self-quarantine is not the employee, name the person and their relationship to employee: _____

In the case of a leave request based solely on a school closing or child-care provider unavailability:
Name the child (or children) and their ages that will be cared for:
_____
Name the school that has been closed or place of care that is unavailable:
_____
Will any other person be providing care for the child (children) during the period for which the employee is receiving family medical leave? ☐ Yes ☐ No
If the child is eighteen years or older, indicate the special circumstance that exists requiring the employee to provide care: _____

Please list date(s) of vaccination:_____

Employee Attestation (to be completed by employee)
My signature affirms that I am not physically able to perform work for my employer through remote access or similar means for the reason indicated above.
Employee Signature: _____Date: _____
Print Employee Name: _____

Employer Attestation (to be completed by employer)
My signature affirms that this employee is not physically able to perform their work through remote access or similar means for the reason indicated above.
Employer Signature: _____Date: _____
Print Employer Name/Entity _____