

EMERGENCY PAID SICK LEAVE (EPSL) or FMLA EXPANSION REQUEST

Employees requesting Emergency Paid Sick Leave (EPSL) or leave under the FMLA Expansion pursuant to the Families First Coronavirus Response Act (FFCRA) must complete this form. You must provide as much advance notice as is reasonably practicable. Upon completion of this form, submit it to your supervisor for signature. Immediately submit the signed form to Human Resources at FAX: 783-9168 or EMAIL: benefits@moreheadstate.edu.

Employee Name:	Date:
Employee MSU ID#:	Department:
This is a <i>(choose one)</i> : <input type="checkbox"/> New request for leave	<input type="checkbox"/> Request for an extension of leave
Anticipated Begin Date of Leave:	Expected Return to Work Date:
Reason for Leave <i>(check all applicable)</i> I am unable to work (or telework) for the following reasons:	
EMERGENCY PAID SICK LEAVE	
Regular Rate of Pay	
<input type="checkbox"/> I am subject to state, federal or local quarantine or isolation order related to COVID-19	
<input type="checkbox"/> I have been advised by a health care professional to self-quarantine due to concerns related to COVID-19	
<input type="checkbox"/> I have symptoms related to COVID-19 and I am seeking a diagnosis	
2/3 Rate of Pay	
<input type="checkbox"/> I am caring for an individual who is subject to quarantine or has been advised to quarantine related to COVID-19.	
Please pay 1/3 using: Sick (# Of hours): _____ Vacation (# of hours) _____	
FMLA EXPANSION	
<input type="checkbox"/> I need to care for my child under age 18 because the child's school, child care or child care provider is closed or unavailable because of COVID-19	
First 10 days unpaid	
Please supplement the unpaid leave using: Sick (# Of hours): _____ Vacation (# of hours) _____	
<input type="checkbox"/> I wish to use EPSL for unpaid days	
For up to 10 weeks following leave (2/3 regular rate of pay)	
Please pay 1/3 using: Sick (# Of hours): _____ Vacation (# of hours) _____	
I will need <i>(choose one)</i> : <input type="checkbox"/> Continuous leave <input type="checkbox"/> Intermittent leave	
If your need for leave is intermittent, please describe the nature of your intermittent leave: _____	

I certify that the above information is accurate and complete. I understand that if I fail to report for work on or before the scheduled return date indicated above or fail to contact Human Resources regarding my absence from work beyond such scheduled date of return, my employer may take corrective action.

Employee Signature: _____

Date: _____

Supervisor Signature: _____

Date: _____