

Emergency Paid Leave Request (COVID-19)

This form must be completed in full and submitted to molly.dequinzio@curry.edu or hr@curry.edu within one day after the first day of absence (or as soon as practicable under the circumstances). **Medical documentation or proof of immunization is required.**

Employee Name: _____ Today's Date: _____

1. I am requesting paid leave beginning on _____ until _____ (expected end date).

Leave may be continuous or used intermittently and on in hourly increments.

- ☐ I am requesting continuous leave, or
☐ I am requesting to take leave *intermittently* or hourly (please describe with as much detail as possible):

2. I am requesting this leave because I am unable to work or telework due to my need to:

- ☐ Self-isolate and care for myself because I have been diagnosed with COVID-19
- ☐ Self-isolate and care for myself -- I have been diagnosed with COVID-19 and my symptoms inhibit my ability telework
- ☐ Seek or obtain medical diagnosis, care or treatment for COVID-19 symptoms
- ☐ Obtain my COVID-19 immunization
- ☐ Recover from an injury, disability, illness or condition related to my COVID-19 immunization
- ☐ Comply with a quarantine or other determination that my presence on the job or in the community would jeopardize the health of others because of my exposure to COVID-19 or symptoms I am exhibiting. The order or determination was made by:
- ☐ A local, state or federal public official (identify): _____
- ☐ A health authority having jurisdiction (identify): _____
- ☐ A health care provider (identify): _____
- ☐ My employer
- ☐ Care for a family member* who is self-isolating due to a COVID-19 diagnosis
- ☐ Care for a family member* who needs medical diagnosis, care or treatment for COVID-19 symptoms
- ☐ Care for a family member* who is under quarantine or other determination that the family member's presence on the job or in the community would jeopardize the health of others because of the family member's exposure to COVID-19 regardless of diagnosis. The order or determination was made by:
- ☐ A local, state or federal public official (identify): _____
- ☐ A health authority having jurisdiction (identify): _____

(continued on next page)

Employee Name: _____ Today's Date: _____

(continued from previous page)

☐ A health care provider (identify): _____

☐ Their employer (identify): _____

* Name and relationship of the family member I will care for: _____

“Family member” means an employee’s spouse, domestic partner, child, parent, grandchild, grandparent, or sibling, a parent of a spouse or domestic partner of the employee, or a person who stood *in loco parentis* (standing in the place of the parent) to the employee when such employee was a minor child. “Child” means an employee’s biological, adopted or foster child, a stepchild or legal ward, a child to whom the employee stands *in loco parentis* or a person to whom the employee stood *in loco parentis* when the person was a minor.

3. EMPLOYEE CERTIFICATION AND SIGNATURE

I understand that my request is not complete until I submit medical documentation for leave related to my or a family member’s diagnosis or treatment for COVID-19, or proof of immunization for leave related to my COVID-19 vaccination.

I understand that my leave request is subject to approval by the Office of Human Resources, and I am eligible for leave only for so long as I am unable to work or telework due to the reason I have indicated and only when work is otherwise available to me.

I will promptly notify Office of Human Resources in writing if there is any change to the statement(s) in this form that I am certifying in support of my request for leave.

I certify that the information I provide is and will be truthful, accurate and complete.

(Employee Signature) DATE: _____

* * *

HUMAN RESOURCES Use Only:

Leave approved: ☐ YES ☐ NO (explain)

- The number of hours in the employee’s regular or average weekly schedule: _____
- Employee’s social security or tax identification number: _____
- Employee’s internal identification number: _____
- Total amount of leave taken (in hours) : _____
- Total wages paid during that leave (not eligible for federal tax credits or otherwise paid under any other government program or law) : _____
- Benefits applicable to the employee taking leave: _____