Muskogee Public Schools
Application for Paid Sick Leave Pursuant to the
Emergency Paid Sick Leave Act (EPSLA)

Name: _______________________________ Date: ________________

Address: ______________________________________________________

Phone #: _______________________________ Email: ________________

Position: ___________________________________ Site: ________________

Anticipated Begin Date of Leave: ___________________________________

Expected Return to Work Date: _____________________________________

The Emergency Paid Sick Leave Act provides paid sick leave to a district employee with a qualifying COVID-19 need under certain specified circumstances when an employee is unable to work or telework.

Pursuant to the Emergency Paid Sick Leave Act, I am unable to work or telework due the following circumstance(s) (Please check below the circumstance(s) for which leave is being requested):

____________ Employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19, (the “Coronavirus”).

____________ Employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

____________ Employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis.

____________ Employee:
   ♦ Is caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

   OR

   ♦ Has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

____________ Employee is caring for his or her son or daughter, (under the age of 18 years old or older but incapable of self-care because of a physical or mental
disability), because the school or place of care of the son or daughter has been closed, or because the child care provider of such son or daughter is unavailable, due to COVID-19 precautions.

________ Employee is experiencing any other 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.

Name of health care provider who advised the employee to self-quarantine for COVID-19 reasons (if applicable):
_____________________________________________________________________________________
_____________________________________________________________________________________

Name of Federal, State or local authority which issued the quarantine or isolation order to which employee is subject (if applicable):
_____________________________________________________________________________________
_____________________________________________________________________________________

Please specify if the quarantine or isolation order was issued to you (employee).
_____________________________________________________________________________________
_____________________________________________________________________________________

If you are not the individual subject to the quarantine or isolation order, please list below the name and relationship to you of the person subject to the order:
_____________________________________________________________________________________
_____________________________________________________________________________________

If you have noted above as the reason for leave your care for a son or daughter under the age of 18 or older but incapable of self-care because of a physical or mental disability, please provide the following information:

_____ Name of child(ren):
_____________________________________________________________________________________

_____ Age of the child(ren):
_____________________________________________________________________________________

_____ Relationship of child(ren) to you:
_____________________________________________________________________________________

School or child care provider which has either closed or become unavailable:
_____________________________________________________________________________________

By signing this form I certify that:

- no other suitable person is available to care for the child(ren), identified above, during the period of leave requested;
- no other person will be providing care for the child(ren) during the period for which I am receiving family medical leave; and
- for any child(ren) identified above who is older than 14 years of age, special circumstances exist which require me to provide care during daylight hours.

IF AVAILABLE please submit with this completed form any documentation you may have at this time supporting your request for leave which may include the following:

- Quarantine or isolation order
- Notice of closure for your child’s school or child care facility
- Prescription record
- Physician’s report

Dated this ______ day of _____________________ 2020.

I certify that the information contained within this form is true and correct to the best of my knowledge. I authorize the District to obtain and verify any necessary information regarding my request. I understand that providing false information may result in corrective action up to, and including, termination of my employment or other penalties as permitted by law.

________________________________________
Employee’s Signature

To be Completed by District Personnel

Request is: □ Approved □ Denied

Staff member: __________________________________________________________

Date: ___________________________________________________________________
Muskogee Public Schools
Application for Paid Sick Leave Pursuant to the
Emergency Family and Medical Leave Expansion Act (EFMLEA)

Name: ____________________________ Date: __________________

Address: ___________________________________________________________________________________

Phone #: __________________________ Email: __________________

Position: __________________________ Site: __________________

Anticipated Begin Date of Leave: ______________________________________________________________

Expected Return to Work Date: _______________________________________________________________

The Emergency Family and Medical Leave Expansion Act provides for up to 12 weeks of job-protected leave for an employee, employed by the District for at least 30 calendar days. To qualify for this job-protected leave, you must be unable to work (or telework) due to a need for leave to care for a son or daughter, under 18 years of age or older but incapable of self-care because of a physical or mental disability, if the child’s school or care provider is unavailable due to a public health emergency. **NOTE: the EFMLEA expands the reasons for which family and medical leave is available but does not provide additional family and medical leave in excess of the 12 weeks available under traditional FMLA. If you have used any or all of your entitlement to FMLA leave during the designated period this may affect your entitlement to emergency family and medical leave.**

Name of child(ren): __________________________

__________________________________________________________________________________________

Age of the child(ren):

__________________________________________________________________________________________

(If under 18 years of age or older but incapable of self-care because of a physical or mental disability)

Relationship of child(ren) to you: ____________________________________________________________

__________________________________________________________________________________________

School or child care provider which has either closed or become unavailable:

__________________________________________________________________________________________

By signing this form I certify that:

- no other suitable person is available to care for the child(ren), identified above, during the period of leave requested;
- no other person will be providing care for the child(ren) during the period for which I am receiving family medical leave; and
for any child(ren) identified above who is older than 14 years of age, special circumstances exist which require me to provide care during daylight hours.

IF AVAILABLE please submit with this completed form any documentation you may have at this time evidencing the closure for your child’s school or child care facility.

Dated this ______ day of ______________________ 2020.

I certify that the information contained within this form is true and correct to the best of my knowledge. I authorize the District to obtain and verify any necessary information regarding my request. I understand that providing false information may result in corrective action up to, and including, termination of my employment or other penalties as permitted by law.

__________________________________________
Employee’s Signature

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<thead>
<tr>
<th>To be Completed by District Personnel</th>
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<tbody>
<tr>
<td>Request is: □ Approved □ Denied</td>
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<tr>
<td>Staff member:________________________</td>
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<tr>
<td>Date:_______________________________</td>
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