

**Application for Leave
Emergency Family and Medical Leave Act Expansion**

Employee Name: _____ Assignment/Building: _____

Employee Address: _____

FMLA Leave Requested: From _____

To _____

Emergency Paid Sick Leave

Under the law, employees are eligible for paid sick leave if they are unable to work (or telework) for **2 weeks of normally scheduled hours**. Listed are the qualifying reasons the employee is eligible to receive Emergency Paid Sick Leave.

Emergency Family and Medical Leave Act Expansion

Under the law this act becomes part of the traditional FMLA which allows employees to access up to **12 weeks of total leave (this includes the 2 weeks of Emergency Paid Sick Leave)**. Listed are the qualifying reasons the employee is eligible to receive Emergency Family and Medical Leave under the Families First Coronavirus Response Act (FFCRA).

****All leave must be taken consecutively***

Please check and complete as appropriate. If applying for numbers 2 or 3, we request a directive from a physician to be emailed to aunistrong@npsne.org or tricianathan@npsne.org or faxed to the Payroll Department at 402-644-2506 when possible.

1. _____ Employee is subject to federal/state/local quarantine or isolation order related to COVID-19
(Pay 100% for Emergency Paid Sick Leave for 2 weeks/up to 10 weeks at no pay)

2. _____ Employee is advised by health care provider to self-quarantine due to COVID-19
(Pay 100% for Emergency Paid Sick Leave for 2 weeks/up to 10 weeks at no pay)

3. _____ Employee is experiencing symptoms of COVID-19 and is seeking a medical diagnosis
(Pay 100% for Emergency Paid Sick Leave for 2 weeks/up to 10 weeks at no pay)

4. _____ Employee is caring for an individual subject to federal/state/local quarantine or isolation order related to COVID-19 or is advised by health care provider to self-quarantine due to COVID-19
(Pay 67% for 2 weeks/up to 10 weeks at no pay)

5. _____ Employee is caring for son/daughter (under age 18) whose school or place of care has been closed or childcare provider is unavailable due to COVID-19 precautions
(Pay 67% for 12 weeks)

6. _____ Employee is experiencing "any other substantially similar condition" specified by the Department of Health and Human Services
(Pay 67% for 2 weeks/up to 10 weeks at no pay)

I certify that the above information given by me is correct and that I have read the foregoing and understand my rights under the EFMLAE.

Employee's Signature Date