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| Employee Name | Employee ID Number | Date |
|  |  |  |
| Title | Supervisor | Department |
|  |  |  |
| Leave Start Date | Leave End Date | Total Hours Requested |
|  |  |  |

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| I certify that am unable to work (or telework) for the following reason:  I am subject to a **federal, state, or local quarantine or isolation** order related to COVID-19 that specifically prevents me from working.  Name of the government entity issuing the order: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have been **advised by a health care provider to self-quarantine** because of concerns related to COVID-19.  Name of the advising healthcare provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I have **symptoms of COVID-19** and I am seeking (or have sought) a diagnosis.  I am **caring for another individual** who is subject to quarantine or has been advised by a health care provider to self-quarantine related to COVID-19. Name of person I am caring for and our relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of the government entity issuing the order: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***OR***  Name of the advising healthcare provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I **need to care for my child(ren)** because their school or childcare provider is closed or unavailable because of COVID-19. **I certify that no other suitable person is available to care for the child(ren) during the period of requested leave.** If listed child is over 14, I further certify that there are special circumstances that require me to provide care for them.  Name(s) and age(s) of child(ren): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Name of closed school(s) or place(s) of care: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    I am experiencing **other conditions substantially similar** to COVID-19 as specified by the Department of Health and Human Services. |

**I certify that the above information is truthful and understand that misrepresenting my need for leave is grounds for discipline, up to and including termination.**

### Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### If signing electronically, please type your full name, followed by “e-signed.”