



**LEAVE REQUEST FORM—EMERGENCY PAID SICK LEAVE**

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<b>Name</b>	<b>Employee ID</b>
<b>Department/campus</b>	<b>Position</b>
<b>Email</b>	<b>Phone number</b>
<b>Date</b>	<b>Duration of leave</b> <i>(specify dates requested)</i>

Leave benefits under the Lubbock ISD Resolution apply for the limited time period of January 1, 2021, to June 30, 2021. The amount of paid leave an employee may receive will vary depending on the reason leave is taken. Detailed information is available in the Resolution notice that can be found on the Human Resources web page.

An employee requesting emergency paid sick leave and expanded family and medical leave must complete this form and return it to \_\_\_\_\_ as soon as the need for leave is identified. Documentation supporting the need for leave should be included when the request is submitted.

Emergency Paid Sick Leave (EPSL) is limited to 80 hours of paid leave at the following rates:

- Self: regular rate of pay up to \$511 per day
- For care of an individual or a son or daughter: two-thirds the regular rate of pay up to \$200 per day

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I request leave for the following reason(s):

**Self**

\_\_\_ I'm subject to a federal, state, or local quarantine or isolation order related to COVID-19.

Name of entity requiring quarantine or isolation: \_\_\_\_\_

\_\_\_ I've been advised to self-quarantine by a health care provider.

Name of health care provider requiring self-quarantine: \_\_\_\_\_

\_\_\_ I'm experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

Name of health care provider: \_\_\_\_\_

I'm experiencing any other substantially-similar conditions specified by the U.S. Department of Health and Human Services.

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**Care for other individual or child**

\_\_\_\_ I'm unable to work in order to care for a minor son or daughter because their school is closed or child care is not available due to COVID-19.

Name of school or child care facility: \_\_\_\_\_

Are you the only adult caring for the child(ren): \_\_\_\_yes \_\_\_\_no

Name and age of child(ren): \_\_\_\_\_

If the son or daughter is over the age of 14 describe special circumstance requiring the care:

\_\_\_\_\_

\_\_\_\_ I'm unable to work in order to care for an individual subject or advised to quarantine or isolate.

Name of individual: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name of health care provider: \_\_\_\_\_

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**Designation** (completed by HR Department and a copy provided to the employee):

\_\_\_\_ The employee qualifies for EPSL.

\_\_\_\_ The employee does not qualify for EPSL.

<p><b>For office use only:</b></p> <p>Date of Employment _____</p> <p>Medical certification provided ____ Yes ____ No</p> <p>Approved by: _____</p> <p style="text-align: center;">Name and title</p> <p>Date: _____</p>
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