Employee Verification for Paid Leave Due to Covid-19 and/or Verification for Alternate Work Arrangements Due to Meeting CDC High Risk Criteria

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I, the undersigned employee, am requesting COVID-19 leave as identified below:

(Please check all that apply).

☐ **Emergency Federal Paid Sick Leave (COVID-19 SICK LEAVE)**

- Maximum of 80 hours paid leave for full-time, prorated for part-time.
- Unable to work or telework because:
  - Health care provider/officer ordered employee quarantined
  - Employee has COVID-19 symptoms
  - Employee care for individual in quarantine
  - Need to care for a minor child whose school or child care is closed
- Pay:
  - 100% pay for employee quarantine or symptoms (up to max of $511.00/day)
  - 2/3 pay for care of another or closed school/child care (max. $200.00/day)

☐ **Emergency Federal Family and Medical Leave (COVID-19 FMLA)**

- Up to 12 weeks (first 10 days unpaid, but may substitute emergency federal sick leave or accrued paid leave; FMLA leave previously used deducted from 12 weeks.)
- Unable to work or telework because:
  - Need to take care for a minor child whose school or child care is closed
  - Qualify as a child care provider for a minor child whose school or child care is closed
- 2/3 of regular pay
- Maximum of $200.00/day

I am requesting leave for the following dates_____and verify my request is for the reasons listed below. *(Please check all that apply).*

1. **School/ Child Care Closure**

☐ My minor child's school, place of care, or child care provider is unavailable due to COVID-19 and I am unable to work as a result.

Name and birthdate of child(ren)_____

**For children over age 14, a statement indicating the special circumstances that require the employee to provide care during daylight hours.*

Name of school, place of care, or child care provider that closed or became unavailable_____.

☐ My supervisor has confirmed there is no telework option available to me.

☐ I have attached a copy of the notice of closure for my child's place of care.

2. **Isolation / Quarantine by Health Care Provider or Federal, State or Local Order**

☐ I have been advised by a health care provider or pursuant to a Federal, State or Local Order to self-quarantine due to concerns related to COVID-19 and I am unable to work as a result.

☐ My supervisor has confirmed there is no telework option available for me.

☐ Written documentation from the health care provider or Federal, State or Local Order advising me to self- quarantine due to concerns related to COVID-19 is attached.

3. **COVID-19 Symptoms and Diagnosis**

☐ I am experiencing COVID-19 symptoms and seeking a medical diagnosis and as a result I am unable to work.

☐ My supervisor has confirmed there is no telework option available for me.

4. Caring for an Individual Due to COVID-19

☐ I am caring for an individual who is subject to a federal, state, or local quarantine or isolation order related to COVID-19 and as a result I am unable to work.

☐ I am caring for an individual who has been advised by a health care provider to self- quarantine due to concerns related to COVID-19 and as a result I am unable to work.

☐ My supervisor has confirmed there is no telework option available for me.

☐ Written documentation from the health care provider advising the individual to self-quarantine due to concerns related to COVID-19 is attached.

5. I Meet High-Risk Category Defined by the U.S. Centers for Disease Control (CDC)

☐ Age 65+

☐ A person *who is* at increased risk of severe illness from Covid-19 as defined by the CDC (see page 4 for list)

☐ A person *who might* be at increased risk of severe illness from COVID-19 as defined by the CDC (see page 4 for list)

I am requesting:

☐ Work at an alternate location (contact your supervisor to discuss options). If you have a suggested location, please identify it here:

_____

☐ Telework (contact your supervisor to discuss options for work to perform remotely).

☐ Documentation to provide to Employment Security Department regarding lack of work in order to apply for benefits.

The name of my treating health care provider is: _____
(Note: employers may request reasonable medical documentation to support the request for those who might be at increased risk)

I understand that any misrepresentations provided as a basis for this request will be a basis for disciplinary action.

I declare under penalty of perjury under the laws of state of Washington the foregoing is true and correct.

Dated this_____day of_____, 2020 at_____, Washington.

Signature:_____ Employee ID: _____

Print Name: _____ Supervisor: _____

Department: _____

Please email form to: HR@ewu.edu, or fax to: 509-359-2874. May interoffice mail to HR in Showalter 314.

CDC Medical Risk Categories for COVID-19

Is at high risk:

- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index [BMI] of 30 or higher)
- Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Sickle cell disease
- Type 2 diabetes mellitus

Might be at increased risk:

- Asthma (moderate-to-severe)
- Cerebrovascular disease (affects blood vessels and blood supply to the brain)
- Cystic fibrosis
- Hypertension or high blood pressure
- Immunocompromised state (weakened immune system) from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines
- Neurologic conditions, such as dementia
- Liver disease
- Pregnancy
- Pulmonary fibrosis (having damaged or scarred lung tissues)
- Smoking
- Thalassemia (a type of blood disorder)
- Type 1 diabetes mellitus