EASTERN WASHINGTON UNIVERSITY

EMPLOYEE VERIFICATION FOR PAID LEAVE DUE TO COVID-19 AND/OR VERIFICATION FOR ALTERNATE WORK ARRANGEMENTS DUE TO MEETING CDC HIGH RISK CRITERIA

I, the undersigned employee, am requesting 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. **<u>School/ Child Care Closure</u>**

☐ 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. (A notice is not required for closure of my child's school under Governor's March 13, 2020 Proclamation)

2. Isolation/Quarantine due to Federal, State or Local Order

☐ My supervisor has confirmed I cannot work at my regular worksite because my work does not qualify as essential business under the Governor's Stay Home-Stay Healthy Proclamation and that there are no duties I can perform remotely or by telework.

3. Isolation / Quarantine by Health Care Provider

☐ I have been advised by a health care provider 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 advising me to self-quarantine due to concerns related to COVID-19 is attached.

4. 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.

5. 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.

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

☐ Age 65+

☐ Other underlying health condition as defined by the CDC

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 (if applicable) is: _____ (please note: you will not be asked to request medical documentation from your health care provider).

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.