MARR JONES & WANG

A LIMITED LIABILITY LAW PARTNERSHIP

Labor and Employment Law

Employee Requests for Emergency Paid Sick Leave and Emergency Family Medical Leave

Update as of April 6, 2020, 1:30 p.m.

The Department of Labor ("DOL") and the Internal Revenue Service ("IRS") have issued "FAQ" guidance, and the DOL has issued regulations to implement the emergency paid sick leave ("EPSL") and the emergency family medical leave ("EFML") provisions of the Families First Coronavirus Response Act ("FFCRA"). Although the guidance is not entirely consistent as between the two agencies and although some ambiguities remain, it is clear that employers may require certain information and supporting documentation from employees who request EPSL and/or EFML.

Attached are sample "leave request forms" for the use of EPSL and EFML, respectively, that employers may tailor for their own specific needs and circumstances. **Please note that the forms, as drafted, may not be appropriate for all covered employers; any employer who uses the forms should review them carefully and modify them as necessary.** Among other issues, intermittent leave may be appropriate for some employers but not others, and the form in which intermittent leave is allowed is likely to differ between employers. These forms are also subject to revision if further guidance is issued by the DOL and/or the IRS.

Beyond the specific information on the sample leave request forms, it is also recommended that employers document their reason(s) for granting or denying the leave. Documentation of a denial is important should an employee challenge the decision. Documentation of a decision to grant the leave is important to support taking the tax credits to pay for the leave.

As a reminder, covered employers are those with fewer than 500 employees as of the date leave is to be taken. Employers with fewer than 50 employees may claim an exemption from EFML and from the school/childcare closure basis for EPSL (but not from other EPSL-qualifying reasons) if providing such leave would jeopardize the viability of the business as a going concern.

Covered employers may exclude employees who are "health care providers" and "emergency responders" from benefits under the FFCRA. Other than for such excluded employees, EPSL is available to employees regardless of their duration of employment, and EFML is available to employees who have been employed for at least 30 days (employees eligible for EFML include employees who were laid off or otherwise terminated on or after March 1, 2020, had worked for the employer for at least 30 of the prior 60 calendar days, and were subsequently rehired or otherwise reemployed by the same employer).

And remember that EPSL and EFML are not available at all unless the qualifying reason prevents the eligible employee from working *or teleworking*.

Our attorneys are available to assist with your FFCRA, CARES Act and other COVID-19-related questions and issues. If you would like the attached forms in Word format, please respond to this e-mail or e-mail your request to your usual point of contact at the firm.

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[COMPANY]
Request Form for Emergency Paid Sick Leave

You may be eligible for Emergency Paid Sick Leave (EPSL) under the Emergency Paid Sick Leave Act (EPSLA) and the Families First Coronavirus Response Act (FFCRA). Please complete the information below and submit this form to _____ as soon as practicable to support your use of EPSL.

Employee Name:	
Employee Home Address:	**E-mail**:
Employee Cell Phone Number:	
This is a *(choose one)*: ☐ **New request**	☐ **Extension of prior request** **Current EPSL End Date:**
Anticipated EPSL Start Date:	**Expected Return to Work Date**:

I am requesting EPSL because I am unable to work or telework for the following reason(s):

☐ 1. I am subject to a federal, state, or local quarantine or isolation order related to COVID-19

☐ 2. I have been advised by a healthcare provider to self-quarantine due to concerns related to COVID-19

☐ 3. I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis

☐ 4. I am caring for an individual who is subject to an order as described in paragraph 1 above, or who has been advised as described in paragraph 2 above.

☐ 5. I am caring for my child who is under 18 (or is 18 or older and incapable of self-care due to disability) and whose school or place of care has been closed, or whose child care provider is unavailable, due to COVID-19 precautions.

☐ 6. I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretary of the Treasury and the Secretary of Labor.

For reasons 1, 2, and 4, please identify the government entity ordering the quarantine/isolation, or the healthcare provider advising self-quarantine, and attach documentation supporting the request:

For reason 4, please also identify the individual's name and relationship to you:

Name: **Relationship:**

For reason 5 only, please complete the following and also attach documentation of your need for leave, such as notice of closure or unavailability from your child's school, place of care, or childcare provider:

Name: _____ Age: _____ School/Provider: _____

Name: _____ Age: _____ School/Provider: _____

Name: _____ Age: _____ School/Provider: _____

(this section continued on next page)

[OPTIONAL. REMOVE OR REVISE THE FOLLOWING DEPENDING WHAT YOU ALLOW]

I am requesting *(choose one)*: ☐ Continuous leave ☐ Intermittent leave

If you are requesting intermittent leave, please describe the nature, including dates and/or intervals (e.g., each Tuesday and Thursday; 8:00 a.m. to noon daily; etc.) of the intermittent leave you are requesting:

_____ *(initial)* **I represent that no other suitable person will be providing care for the child(ren) listed above during the period for which I am receiving EPSL.**

[SELECT ONE OF THE TWO OPTIONS BELOW]

OPTION 1: For any child(ren) older than 14, the following special circumstances exist requiring me to provide care during daylight hours:

OPTION 2: ___ *(initial)* **I hereby certify that there are special circumstances requiring me to provide care for any child(ren) older than 14 during daylight hours.**

I certify that the above information is accurate and complete. I understand that providing false or misleading information regarding the need for EPSL or any FFCRA qualifying event will be grounds for corrective action, up to and including termination. I further understand that if I fail to report to work on or before the scheduled return date indicated above or fail to contact _____ regarding my absence from work beyond such scheduled date of return, my employer may take corrective action.

Employee Signature: **Date:**

☐ **Approved** ☐ **Denied** **Signature:** **Date:**

[COMPANY]
Request Form for Emergency Family Medical Leave

Employees who have worked for [COMPANY] for at least thirty (30) calendar days may be eligible for Emergency Family Medical Leave (EFML) pursuant to the Emergency Family and Medical Leave Expansion Act (EFMLEA) and the Families First Coronavirus Response Act (FFCRA). If your need for leave is foreseeable, you must provide notice of your need for leave as soon as practicable. Please provide the information below and submit this form to _____.

Employee Name:
Employee Home Address: **E-mail**:
Employee Cell Phone Number:
This is a *(choose one)*: ☐ **New request** ☐ **Extension of prior request** **Current EFML End Date**:
Anticipated EFML Start Date: **Expected Return to Work Date**:
I am requesting EFML because I am unable to work or telework for the following reason: ☐ I need to care for my child(ren) under age 18 (or 18 or older and incapable of self-care due to disability) because my child(ren)'s elementary or secondary school has been closed due to a public health emergency ☐ I need to care for my child(ren) under age 18 (or 18 or older and incapable of self-care due to disability) because my child(ren)'s place of care has been closed due to a public health emergency ☐ I need to care for my child(ren) under age 18 (or 18 or older and incapable of self-care due to disability) because my child(ren)'s childcare provider is unavailable due to a public health emergency
The name(s), age(s), and school/provider of my child(ren) needing care are as follows: Name: _____ Age: _____ School/Provider: _____ Name: _____ Age: _____ School/Provider: _____ Name: _____ Age: _____ School/Provider: _____
_____ *(initial)* **I represent that no other suitable person will be providing care for the child(ren) listed above during the period for which I am receiving EFML.**
[SELECT ONE OF THE TWO OPTIONS BELOW] **OPTION 1: For any child(ren) older than 14, the following special circumstances exist requiring me to provide care during daylight hours:** **OPTION 2: ___ *(initial)* I hereby certify that there are special circumstances requiring me to provide care for any child(ren) older than 14 during daylight hours.**

Please attach documentation of your need for leave, such as notice of closure or unavailability from your child(ren)'s school, place of care, or childcare provider.

[OPTIONAL. REMOVE BOX OR REVISE LANGUAGE DEPENDING ON WHAT YOU ALLOW]

I am requesting *(choose one)*: ☐ Continuous leave ☐ Intermittent leave

If you are requesting intermittent leave, please describe the nature, including dates and/or intervals (e.g., each Tuesday and Thursday; 8:00 a.m. to noon daily; etc.) of the intermittent leave you are requesting:

Substitution of paid leave. Pursuant to the FFCRA, the first two weeks of your leave are unpaid. However, you may be eligible for Emergency Paid Sick Leave ("EPSL") provided through the FFCRA. If so, the EPSL will run concurrently with the first two weeks of EFML. If you are not eligible for, or if you have exhausted, EPSL, you may use any other accrued paid leave during the first two weeks of EFML. Please indicate below how many hours you elect and plan to use. **[MODIFY BASED ON TYPES OF LEAVE OFFERED]**

☐ Vacation/PTO ___ hrs ☐ Sick leave ___ hrs ☐ Personal leave ___ hrs ☐ Other ___hrs

[THE FOLLOWING LANGUAGE IS OPTIONAL] For the remaining period of EFML during which you are paid 2/3 of your wages (if applicable), you may use any accrued paid leave to supplement the 2/3 pay. Please indicate below how many hours you elect and plan to use. **[MODIFY BASED ON TYPES OF LEAVE OFFERED]**

☐ Vacation/PTO ___ hrs ☐ Sick leave ___ hrs ☐ Personal leave ___ hrs ☐ Other ___hrs

I certify that the above information is accurate and complete. I understand that providing false or misleading information regarding the need for EFML or any FFCRA qualifying event will be grounds for corrective action, up to and including termination. I further understand that if I fail to report to work on or before the scheduled return date indicated above or fail to contact _____ regarding my absence from work beyond such scheduled date of return, my employer may take corrective action.

Employee Signature: **Date:**

☐ **Approved** ☐ **Denied** **Signature:** **Date:**