CITY OF SAINT PETER

Request for Emergency Paid Sick Leave 04/01/2020

For employees to request emergency paid sick leave under the Families First Coronavirus Response Act ("FFCRA").

Effective April 1, 2020, despite the city having work available for you, if you are unable to work, or telework because of the COVID-19 pandemic, you may be eligible for paid sick leave under new federal legislation. Paid sick leave under the Emergency Paid Sick Leave Act is in addition to other leave provided under Federal, State, or local law; an applicable collective bargaining agreement; or the city's accrued leave benefits. This Emergency Paid Sick Leave benefit is scheduled to expire on December 31, 2020 under the FFCRA and is not eligible for pay out at termination of employment.

You will be paid as noted below. Full-time employees may take up to 80 hours of paid emergency sick leave for a qualifying reason. Part-time employees may take the number of hours they typically work in an average two-week period. To request paid emergency sick leave, please complete the information below.

Employee Name:

_____

Despite the city having available work for me, I certify I am unable to work or telework at this time due the following reason (check one of the applicable boxes):

☐ **I am subject to a Federal, State or local quarantine or isolation order related to COVID-19.** *I have attached to this form a copy of* Governor Walz's Stay at Home Executive Order (found here)

I am requesting Emergency Paid Sick Leave at my regular rate of pay for two weeks, up to a cap of $511/day or $5,110 total over the entire two-week Emergency Paid Sick Leave period for the following dates:

From (date): _____ to (date): _____

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

Name of Health Care Provider who advised me to self-quarantine for COVID-19 related reasons:

_____

I am requesting Emergency Paid Sick Leave at my regular rate of pay for up to two weeks, up to a cap of $511/day or $5,110 total over the entire two-week Emergency Paid Sick Leave period for the following dates:

From (date): _____ to (date): _____

☐ **I am experiencing COVID-19 symptoms and am seeking a medical diagnosis**

Name of Health Care Provider I am contacting:

_____

I am requesting Emergency Paid Sick Leave at my regular rate of pay for up to two weeks, up to a cap of $511/day or $5,110 total over the entire two-week Emergency Paid Sick Leave period for the following dates:

From (date): _____ to (date): _____

☐ **I am caring for an individual who is subject to a Federal, State or local quarantine or isolation order related to COVID-19; or who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.**

Name of Individual: _____

*Relationship to Employee: _____

*Must be an immediate family member, roommate, or a similar person with whom the employee has a relationship that creates an expectation that the employee would care for the person due to the quarantine.

Please specify why employee is unable to work because of the reason for leave:_____

_____

I have attached to this form a copy of Governor Walz's Stay at Home Executive Order (found here), or

Name of Health Care Provider who advised identified individual to self-quarantine for COVID-19 related reasons:

_____

I am requesting Emergency Paid Sick Leave at 2/3 my regular rate of pay for up to two weeks, up to a cap of $200/day or $2,000 total over the entire two-week Emergency Paid Sick Leave period for the following dates:

From (date): _____ to (date): _____

☐ **I am caring for my minor child whose school or place of care is closed (or child-care provider is unavailable) to due to COVID-19 related reasons.** *Per Department of Labor April 1 Guidance, Emergency Paid Sick Leave is only for the period when the employee needs to, and actually is, caring for his or her child. I assert no other suitable person is available to care for the child during the period of this requested leave.*

From (date): _____ to (date): _____

Name of Child: _____ Age: _____

Relationship to Employee:

_____

Name and City of School or Child Care Center/Provider the child is enrolled at:_____

Name of Child: _____ Age: _____

Relationship to Employee:

_____

Name and City of School or Child Care Center/Provider the child is enrolled at:_____

Name of Child: _____ Age: _____

Relationship to Employee:

_____

Name and City of School or Child Care Center/Provider the child is enrolled at:_____

I am requesting Emergency Paid Sick Leave at 2/3 my regular rate of pay for up to two weeks, up to a cap of $200/day or $2,000 total over the entire two-week Emergency Paid Sick Leave period for the following dates:

From (date): _____ to (date): _____

Please Note: With the care of a child older than 14 during daylight hours, you must include a statement that special circumstances exist requiring the employee to provide care.

☐ **I am experiencing a substantially similar condition, as specified by the U.S. Department of Health and Human Services**.

I am requesting Emergency Paid Sick Leave at 2/3 my regular rate of pay for up to two weeks, up to a cap of $200/day or $2,000 total over the entire two-week Emergency Paid Sick Leave period for the following dates:

From (date): _____ to (date): _____

☐ **I wish to use my accrued city leave balances to supplement any of the payments made to me at the 2/3 pay rate.**

- I certify the above information is true and accurate to the best of my knowledge.
- I understand pursuant to federal regulations, payments made to employees taking paid leave pursuant to the FFCRA are not subject to the employer portion of the OASDI tax imposed by Section 3111(a) of the IRS Code, which is also known as the social security tax.

_____ _____

Employee Signature Date