THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA
FAMILIES FIRST CORONAVIRUS RESPONSE ACT (FFCRA)

REQUEST FOR LEAVE UNDER THE EMERGENCY PAID SICK LEAVE ACT (EPSLA)

The EPSLA entitles full-time and part-time employees, who are unable to work due to one of six (6) reasons having to do with COVID-19, up to two weeks of paid sick leave. Part-time employees are eligible for paid sick leave for the average number of hours worked over a two week period. Verbal or e-mail notice of the need for leave will be accepted until related application and documentation are provided.

Name: _____ Personnel # _____

Mailing Address: _____

Daytime Telephone Number: _____ E-mail Address: _____

School/Department Name: _____ Position: _____

Date last worked: _____ Date returned to work: _____

THE REASON FOR THIS EPSLA REQUEST IS (please check only one):

☐ **(1)** I am subject to a Federal, State or local quarantine or isolation order related to COVID–19

Name of government entity that issued the shelter in place, stay at home, etc. order:
_____

☐ **(2)** I have been advised by a health care provider to self-quarantine due to COVID–19 – **Attach proof of test**

☐ **(3)** I am experiencing symptoms of COVID–19 and seeking a medical diagnosis – **Attach proof of test**

☐ **(4)** I am caring for an individual subject to 1 or 2 above – **Attach proof of test**

Name of Individual: _____**Relationship:** _____

☐ **(5)** I am caring for a son/daughter, under age 18 (over age 18, if incapable of self-care due to a mental or physical disability), because the school/place of care or childcare provider is unavailable, due to COVID-19 related reasons.

_____ _____
Child's Name & School/Place of Care or Care Provider's Name **Child's Name & School/Place of Care or Care Provider's Name**

_____ _____
Child's Name & School/Place of Care or Care Provider's Name **Child's Name & School/Place of Care or Care Provider's Name**

☐ **(6)** I am experiencing other substantially-similar condition specified by the US Department of Health and Human Services – **Attach documentation**

FOR REASONS #4, 5, OR 6 ONLY

☐ I elect to supplement EPSL with my accrued paid time (vacation, sick, compensatory time, etc.).

☐ I **do not** elect to supplement EPSL with my accrued paid time (vacation, sick, compensatory time, etc.).

I certify that the above request for Emergency Paid Sick Leave is true and accurate. By making this request, I understand that The School Board of Broward County has the right to request additional information to determine eligibility for Emergency Paid Sick Leave. I understand that any falsification in furtherance of this request may result in disciplinary action, up to and including termination.

Employee's Signature: _____ **Date:** _____

LEAVES DEPARTMENT USE ONLY

Not Eligible Reason: _____

Approved By: _____ **Date:** _____
Chief Financial Officer, The School Board of Broward County, FL

Mail or fax application and required documentation to:
The Leaves Department – 7770 West Oakland Park Boulevard, Sunrise, FL 33351
TEL: (754)321-3130 - FAX: (754)321-3140

Revised 8/10/20