

City of Houston
Human Resources Department
Application for Emergency Paid Sick Leave (EPSL)

The Emergency Paid Sick Leave Act (EPSLA) in general, provides eligible employees of Covered Employers with *Emergency Paid Sick Leave (EPSL)* for 80 hours (i.e., two work weeks) for only six specific reasons listed below in Section II. The *EPSLA* allows an employer to exclude employees who are health care providers or emergency responders from *Emergency Paid Sick Leave* coverage. This form is to be used pursuant to and in accordance with A.P. 3-37 (including without limitation, the terms defined therein).

SECTION I – Employee Information

Name: _____ Employee #: _____

Home Address: _____
(Street # and Name) (City) (State) (Zip)

Home Telephone: _____ Work Telephone: _____ Cell Telephone: _____

Email: _____

Department & Division: _____

Supervisor's Name: _____ Supervisor's Telephone: _____

SECTION II – Reason For *Emergency Paid Sick Leave* (CHECK ONLY ONE BOX BELOW)

 **Select only
One Reason
for Emergency
Paid Sick**

<input type="checkbox"/> (1) The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19. The amount paid to the employee is equal to the employee's regular rate of pay, up to a maximum of \$511 per day (\$5,110 in the aggregate). Please provide the name of the government entity that issued the quarantine or isolation order: _____	<input type="checkbox"/> (2) The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. The amount paid to the employee is equal to the employee's regular rate of pay, up to a maximum of \$511 per day (\$5,110 in the aggregate). Please provide the name of the health care provider who advised the employee to self-quarantine due to concerns related to COVID-19 _____
<input type="checkbox"/> (3) The employee is experiencing symptoms of COVID-19 and seeking a medical diagnosis. The amount paid to the employee is equal to the employee's regular rate, up to a maximum of \$511 per day (\$5,110 in the aggregate). Please provide the name of the health care provider from whom the employee is seeking a medical diagnosis: _____	<input type="checkbox"/> (4) The employee is caring for an individual who is subject to a quarantine or isolation order as described in (1) or has been advised as described in (2). The amount paid to the employee is two-thirds of the employee's regular rate of pay, up to a maximum of \$200 per day (\$2,000 in the aggregate). <u>Please provide the requested items in (1) or (2), as applicable:</u> _____
<input type="checkbox"/> (5) The employee is caring for a son or daughter whose school or place of care has been closed, or the child care provider is unavailable, due to COVID-19 (<i>Employee must fill out child information in Section III below.</i>) The amount paid to the employee is two-thirds of the employee's regular rate of pay, up to a maximum of \$200 per day (\$2,000 in the aggregate).	<input type="checkbox"/> (6) The employee is experiencing 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. The amount paid to the employee is two-thirds of the employee's regular rate of pay, up to a maximum of \$200 per day (\$2,000 in the aggregate). The HR Director or designee in accordance with the EPSLA and any regulations issued by the Dept. of Labor will determine sufficient documentation.

SECTION III – Child(ren) Information (complete only if #5 above is checked)

Please initial below

_____ I am requesting *EPSL*, as I am unable to work (or telework) due to a need to care for my son(s) or daughter(s) because the child’s school or place of care has been closed, or the child care provider is unavailable, for reasons related to COVID-19 AND no other suitable person will be providing care for the son or daughter during the period requested for leave. Generally, an employee does not need to take such leave if another suitable individual— such as a co-parent, co-guardian, or the usual child care provider—is available to provide the care the employee’s child needs.

Name of Son(s) or Daughter(s)	Name, School, Place of Care, or Child Care Provider	School, Place of Care, or Child Care Provider Currently Closed for reasons related to COVID-19
(1)		<input type="checkbox"/> Yes <input type="checkbox"/> No
(2)		<input type="checkbox"/> Yes <input type="checkbox"/> No
(3)		<input type="checkbox"/> Yes <input type="checkbox"/> No

EMPLOYEE MUST IMMEDIATELY NOTIFY HUMAN RESOURCES WHEN THE CHILD(REN)’S SCHOOL, PLACE OF CARE OR PROVIDER REOPENS OR BECOMES AVAILABLE.

EMPLOYEE SHALL SUBMIT SUFFICIENT SUPPORTING DOCUMENTATION IN COMPLIANCE WITH AP 3-37: EMERGENCY PAID SICK LEAVE

SECTION III (A) – STATEMENT OF SPECIAL CIRCUMSTANCE EXIST

If you are requesting leave due to your inability to work or telework because of extenuating circumstances, such as serious COVID-19 symptoms, please provide a written statement below describing the special circumstances that exist:

SECTION IV - Employee Election of *EPSL*

During my sick leave absence, I want to: (INITIAL ONLY ONE OPTION BELOW)

Option 1

_____ Utilize my *Emergency Paid Sick Leave* (limited to 80 hours for full-time employees, fewer hours for part-time employees). If my *EPSL* is less than my regular pay rate, I want to use my appropriate accrued personal, sick, compensatory, and/or vacation leave to bridge the difference.

Option 2

_____ Utilize *only* my *Emergency Paid Sick Leave* (limited to 80 hours for full-time employees, fewer hours for part-time employees), and I know I may receive less than my regular rate of pay depending on the basis for the leave.

Option 3

_____ Utilize *only* unpaid leave, resulting in me receiving no pay during this time.

SECTION V – Certification Statement

I certify that the information above is accurate. I also know I must notify my immediate supervisor and/or Human Resources immediately if any of the information above should change. I am requesting that my EPSL begin on _____ and conclude at the end of my regularly scheduled shift on _____.

MM/DD/YYYY

MM/DD/YYYY

I acknowledge that if the City (i.e. my Department Director, the Human Resources Director or designee, or the Office of Inspector General) determines that I have received benefits under the EPSLA fraudulently or knowingly made a false statement in requesting or continuing ESPL, I shall be subject to corrective action up to and including an indefinite suspension or termination. I also acknowledge that I will be responsible for repaying the City for any fraudulent leave payments received, which may include the use any of appropriate accrued leave during the time I used ESPL fraudulently and/or a repayment plan.

Employee Signature: _____ **Date:** _____

The employee's request for *EPSL* is not approved until this application is completed, sufficient supporting documentation has been submitted (if needed), AND the employee is advised by a HR representative of the employee's approval.