The Texas A&M University System

Emergency Paid Sick Leave (EPSL) under ARPA Request Form

To request paid sick leave for absences related to the coronavirus, please complete the following request form and submit to your manager either prior to leave or as soon as possible after leave commences. Verbal notice will be accepted until a form can be completed. Documentation supporting the need for leave must be included with this request.

Employee name (print clearly): _____

Department: _____ UIN: _____

Manager: _____

Requested leave start date: _____ End date: _____

Number of hours of paid sick leave requested: _____

Emergency Paid Sick Leave (EPSL) provides *up to 80 hours* of emergency paid sick leave for employees (*applicable to ALL employee types*: faculty, staff, students) who are unable to work (including those who are unable to work remotely) **AND** who meet one of nine qualifying reasons related to COVID-19 (listed below). The American Rescue Plan Act (ARPA) paid leave provisions are effective on **April 1, 2021** and apply to leave taken between April 1, 2021 and September 30, 2021. These paid leave provisions are not retroactive beyond April 1, 2021.

❑ I wish to take intermittent leave during the following days and hours (optional):

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

I am requesting this paid sick leave due to my inability to work (or work remotely) because (check the appropriate reason below):

- ☐ 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 health care provider to self-quarantine due to concerns related to COVID–19.
- ☐ 3. I am experiencing symptoms of COVID–19 and seeking a medical diagnosis.
- ☐ 4. I am obtaining a COVID-19 vaccination.
- ☐ 5. I am recovering from an illness related to receiving a COVID-19 vaccination.
- ☐ 6. I am seeking or waiting for test results or a medical diagnosis for COVID-19, including results or diagnosis requested by the employer.
- ☐ 7. I am experiencing another substantially similar condition specified by the secretary of health and human services.
- ☐ 8. I am caring for an individual who is subject to either number 1 or 2 above.
- ☐ 9. I am caring for my child whose primary or secondary school or place of care has been closed, or the child care provider is unavailable due to COVID–19 precautions; and,
    - o No other suitable person is available to care for my child during the requested period of leave.
    - o Special circumstances exist requiring the need for leave to care for my child ages 15-17.

I have attached appropriate documentation supporting my need for leave.

Employee Signature: _____ Date: _____

Manager Signature: _____ Date: _____

HR Dep Rep Signature: _____ Date: _____

Employee Statement Supporting Leave

I, _____, provide the following information in support of my request for coronavirus-related paid sick leave (complete all that apply):

Leave due to a government-issued quarantine or isolation order.

Name of the issuing government agency for the quarantine or isolation order:

_____

Effective dates of the order: _____

Leave due to a health care provider's advice to self-quarantine.

Name of the health care provider advising me or the individual I am caring for to self-quarantine:

_____

Written documentation is available and attached: ❑Yes ❑No

Name and relation of the individual who I am needed to care for:
Name: _____ Relation:_____

Leave due to a school or place of child care closed due to COVID-19.

Name of school or place of care:

_____

Name of child care provider unavailable due to concerns related to COVID-19:

_____

Name and age of child or children I am needed to care for:
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

No other suitable person is available to care for my child for the requested leave period due to:

_____
_____

The special circumstances requiring my need for leave to care for a child age 15-17 are:

_____
_____

Leave due to obtaining a COVID-19 vaccination.

Date(s) COVID-19 vaccination received: _____

Written documentation is available and attached: ❑Yes ❑No

Leave due to recovering from an illness related to receiving a COVID-19 vaccination.

Date(s) COVID-19 vaccination received: _____

Date(s) of COVID-19 vaccination-related illness: _____

Leave due to seeking or waiting for test results or a medical diagnosis for COVID-19, including results or diagnosis requested by the employer.

Name of the health care provider providing the test results or diagnosis:

_____

Written documentation is available and attached: ❑Yes ❑No

Leave due to a substantially similar condition specified by the secretary of health and human services.

Provide details regarding the need for this leave:

_____

_____

I attest that the above information is accurate and complete. I understand falsification of any information given may lead to disciplinary action.

Employee signature: _____ Date: _____