Emergency Paid Sick Leave Form

To Be Completed by the Employee:

First Name:_____ Last Name:_____Date of Hire:_____

Date Leave will Begin:_____Anticipated Length of Leave: _____

Employee ID:_____Full Time ☐ Part Time ☐

Eligible Employees: Full Time Employees will be provided with 80 hours of emergency paid sick leave. Part- Time Employees are capped at the number of hours they work on average over a two-week time frame. This will be a new balance in Workforce. Full Time and Part-Time employees are eligible if they are unable to work or telework for the following items listed below.

Employee: Please complete the following information and select the category that represents your need for leave. Please provide documentation as necessary to Human Resources – Benefits.Please note that options 1-3 are limited to no more than $511.00 in pay per day and no more than $5110.00 in pay total. You cannot make more than your current salary, but you may make less. Options 4-6 are limited to no more than $200.00 per day for each eligible employee or $2000.00 total. You cannot make more than your current salary, but you may make less.

Please mark the box that best applies to your situation:

☐ 1. You have been quarantined or given an isolation order by federal, state or local government due to COVID19.(Pay is no more than $511.00 per day or $5110.00 total.)

Please state the name of the entity ordering quarantine: _____

☐ 2. You have been advised by a healthcare provider to self-quarantine due to COVID-19 concerns. (Pay is no more than $511.00 per day or $5110.00 total.)

Attach Doctor's note, Name of Doctor: _____

☐ 3. You have symptoms of COVID-19 and you are seeking a medical diagnosis. (Pay is no more than $511.00 per day or $5110.00 total.)

Name of Doctor: _____

☐ 4. You are caring for an individual who is subject to a quarantine order or advised to self-quarantine. (Pay is no more than $200.00 per day or $2000.00 total.)

Name of individual and relationship: _____

☐ 5. You are caring for your legal child, under the age of 18, if the school or place of care is closed and no other child care is available due to COVID-19 precautions or restrictions. (Pay is 2/3 your rate of pay; no more than $200.00 per day or $2000.00 total.) If using this leave, you must also complete and attach the Emergency Child Care Form.

☐ 6. You are experiencing "substantially similar conditions" as specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and Secretary of Labor. (Pay is no more than $200.00 per day or $2000.00 total.)

I have read the above eligibility rules and certify that I am unable to work from home and unable to telecommute. I also understand that I may be required to provide documentation and that if I fail to provide the required documentation, any emergency paid sick leave that I was granted may be replaced by other accrued leave. I have selected how I wish to use my Emergency Paid Sick Leave, and understand that I may not always be paid at my full rate of pay.

Employee Signature:_____ Date:_____

Supervisors Signature:_____ Date:_____

Please maintain a copy, send original to benefits, and scan and email to benefits@cityofomaha.org. Once approved, we will notify your supervisor, your timekeeper will enter time.

**Emergency First Responders do not qualify for this leave.