TOWN OF WESTFORD
DEPARTMENT OF HUMAN RESOURCES
TOWN HALL
55 MAIN STREET
WESTFORD, MASSACHUSETTS 01886
Telephone (978)399-2915 Fax (978)399-2571
https://westfordma.gov/274/Human-Resources

EMPLOYEE REQUEST FOR LEAVE UNDER THE EMERGENCY PAID SICK LEAVE ACT AND/OR THE EMERGENCY FAMILY MEDICAL LEAVE ACT

Employee's Name: _____

PART A: REASON FOR REQUESTED LEAVE. Please select the category for which you are requesting Paid Sick Leave under the Emergency Paid Sick Leave Act ("EPSLA") and, if applicable, fill in the corresponding blanks with the requested information below:

☐ ***Category 1*:** I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19. The name of the government entity that issued the order to which I am subject is: _____.

☐ ***Category 2*:** I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19, meaning that the health care provider has advised me to self-quarantine because they believe that I have COVID-19, I may have COVID-19, or I am particularly vulnerable to COVID-19. The name of the health care provider who advised me to self-quarantine for COVID-19 related reasons is: _____
_____.

☐ ***Category 3*:** I am experiencing symptoms of COVID-19 and seeking a medical diagnosis. I understand that leave taken for this reason is limited to the time I am unable to work because I am taking *affirmative* steps to obtain a medical diagnosis, and that I am not permitted to take leave to self-quarantine without seeking a medical diagnosis. I will promptly inform the Town of my diagnosis.

☐ ***Category 4, Part A:*** I am caring for an individual who is subject to a Federal, State, or local quarantine or isolation order related to COVID-19. The name of the individual I am caring for is: _____ and their relation to me is: _____. The name of the government entity that issued the order to which the individual who I am caring for is subject to is:
_____.

☐ ***Category 4, Part B*:** I am caring for an individual who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19. The name of the individual I am caring for is: _____ and their relation to me is: _____. The name of the health care provider who advised the individual who I am caring for to self-quarantine for COVID-19 related reasons is: _____.

☐ ***Category 5*:** I am caring for a son or daughter whose school or place of care has been closed and/or whose child care provider is unavailable due to COVID-19 precautions. The name(s) and age(s) of the child(ren) being cared for is/are: _____ _____ _____. The name of the schools, places of care, or child care providers that is/are closed/unavailable due to COVID-19 reasons is/are: _____.

By signing below, I represent that no other suitable person is available to care for the child(ren) during the period of leave I am requesting.

☐ ***Category 6*:** I am experiencing any 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.

PART B: DURATION OF LEAVE REQUEST. Please indicate the requested start and end dates for Paid Sick Leave:

- Start Date: _____
- End Date: _____

PART C: ABILITY TO WORK ON SITE. **For *Category 5* requests only**, please also indicate if you are able to work on site. If you are, please describe your availability to work on site:

- Sundays: _____
- Mondays: _____
- Tuesdays: _____
- Wednesdays: _____
- Thursdays: _____
- Fridays: _____
- Saturdays: _____

PART D: ABILITY TO WORK REMOTELY. For all requests (*Categories 1 – 6)*, please select one:

☐ I am unable to work remotely

☐ I am able to work my normal hours and normal schedule remotely

☐ ***Request for flexible schedule (no change in number of hours).*** I am <u>able</u> to work my normal hours remotely, but not on my normal schedule. Instead, I am available and am requesting to work my normal number of hours on the following schedule:

- Sundays: _____
- Mondays: _____
- Tuesdays: _____
- Wednesdays: _____
- Thursdays: _____
- Fridays: _____
- Saturdays: _____

☐ ***Request for a reduction in hours and a flexible schedule.*** I am unable to work my normal number of hours remotely. Instead, I am available and am requesting to work the following number hours on the following schedule:

- Sundays: _____
- Mondays: _____
- Tuesdays: _____
- Wednesdays: _____
- Thursdays: _____
- Fridays: _____
- Saturdays: _____

PART E: REQUEST FOR EMERGENCY FAMILY MEDICAL LEAVE ACT

If you are requesting leave under ***Category 5*** (because your son or daughter's school is closed or child care provider unavailable), are you also seeking leave under the Emergency Family Medical Leave Act? ***Yes / No*** *(please circle one)*

If you are also seeking leave under the Emergency Family Medical Leave Act, what are the dates for which you are seeking leave?

Start Date: _____
End Date: _____

PART F: SEQUENCING/SUPPLEMENTING WITH OTHER FORMS OF LEAVE

If you have other forms of appropriate paid leave available to use under the Company's policies, please indicate (yes/no) for the following:

- Do you wish to use other forms of paid leave available to you under the Company's policies <u>first</u> prior to using any leave that you may be eligible for under the Emergency Paid Sick Leave Act?
  Yes / No (please circle one)

- Do you wish to use other forms of paid leave available to you in order to supplement the paid leave amounts (up to 100% of your normal daily rate of pay)?
  Yes / No (please circle one)

PART G: CERTIFICATION

The Town of Westford (the "town") has provided me with notice of my rights under the Emergency Family Medical Leave Act ("EFMLA") and the Emergency Paid Sick Leave Act ("EPSLA"). I understand that by completing this Form, I am making a request for leave pursuant to the EFMLA and/or the EPSLA, which will be evaluated by the Town and the request may be approved or denied under the applicable laws, regulations, and guidance. I understand that if I am requesting to work on an intermittent basis or outside of my normal work hours, the Town can approve or deny that request in whole or in part. I agree to cooperate with the Town with its evaluation of my request for leave and/or to work on an intermittent basis or outside of my normal work hours and to provide the Town with the requested certifications as soon as practicable. I understand that providing false or misleading information in support of my request for leave may result in the imposition of discipline, up to and including termination of employment. Further, I hereby certify that the requested reason for leave is accurate.

_____ _____

Print Employee Name Employee Signature

Date: _____

PLEASE SUBMIT ALL REQUESTS TO PHICKS@WESTFORDMA.GOV