The Nassau County School District

1201 Atlantic Avenue
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"Empowering Others Through a Commitment to Excellence"

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Emergency Paid Sick Leave Provision – COVID-19

Families First Coronavirus Response Act - Effective April 1, 2020 through December 31, 2020

The Act provides paid sick leave for employees impacted by COVID-19 and those serving as caregivers for individuals with COVID-19 through (1) a new federal paid sick leave law and (2) an emergency expansion of the Family and Medical Leave Act (FMLA). The bill was signed by the President on March 18, 2020. The paid sick leave provided under this Act has no impact on your accrued sick leave.

Legal Name _____ **School/Location** _____

Position/Title _____ **Employee ID** _____

Home/Cell Phone _____ **Email** _____

Please answer the following questions:	YES	NO
Are you capable of performing the essential functions of your position?		
Are you capable of performing the essential functions of your position, if given the option to telework?		

Please note that for reasons 1, 2, 3, 4, and 6, a return to work note will be required and the sick leave period must be taken as consecutive days. You are entitled to request a maximum of 10 consecutive work days. You are not required to request to take all 10 days, but you may not request to take them intermittently.

Please select the reason(s) that apply to you by checking the appropriate box(es):

☐ 1 **I am subject to a federal, state or local quarantine or isolation order related to COVID-19.**
**I understand I can receive up to 10 days of sick leave at 100% of my daily rate of pay based upon my regularly scheduled hours.*

Sick Leave Dates Requested: _____

Government Entity that issued quarantine or isolation order: _____

☐ 2 **I was advised by a health care provider to self-quarantine due to concerns related to COVID–19.**
**I understand I can receive up to 10 days of sick leave at 100% of my daily rate of pay based upon my regularly scheduled hours.*

Sick Leave Dates Requested: _____

Name of Health Care Provider that advised you to quarantine or self-isolate: _____

☐ 3 **I am experiencing symptoms of COVID-19 and seeking a medical diagnosis.**
**I understand I can receive up to 10 days of sick leave at 100% of my daily rate of pay based upon my regularly scheduled hours.*

Sick Leave Dates Requested: _____
Please explain and attach pertinent documentation to support your claim:

Our mission is to develop each student as an inspired life-long learner and problem-solver with the strength of character to serve as a productive member of society.

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Legal Name _____ **School/Location** _____

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☐ 4 **I am caring for an individual subject to a federal, state or local quarantine or isolation order or have been advised by a health care provider to self-quarantine due to COVID-19 concerns.**
**I understand I can receive up to 10 days of sick leave at 2/3 of my daily rate of pay based upon my regularly scheduled hours (max $200/day).*

Sick Leave Dates Requested: _____

Name of Person Receiving Care: _____ Relationship to You: _____

Government Entity or Health Care Provider that issued quarantine or isolation order: _____

☐ 5 **I am caring for a son/daughter whose school or place of care is closed, or whose childcare provider is unavailable.**
I understand I can receive up to 10 days of sick leave at 2/3 of my daily rate of pay based upon my regularly scheduled hours (max $200/day). You are **not required to take all 10 days, and you do not need to request to take them consecutively. You may request to take them intermittently.*

Sick Leave Dates Requested: _____

Child(ren)'s Name(s) and Age(s): _____

_____

Name of Closed School(s), Place(s) of Care or Childcare Provider(s): _____

_____

Please provide a statement that no other suitable person will be caring for the child(ren) during the sick leave period:

_____

_____

☐ 6 **I am experiencing a substantially similar condition, to those described above, as specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.**
**I understand I can receive up to 10 days of sick leave at 2/3 of my daily rate of pay based upon my regularly scheduled hours (max $200/day).*

Sick Leave Dates Requested: _____
Please explain and attach pertinent documentation to support your claim:

If you selected reason(s) 4, 5, or 6 above, please answer the following question:

	YES	NO
Do you wish to use your accrued sick or vacation leave to cover the 1/3 of your daily rate of pay not provided for under this Act?		

The Human Resources Department reserves the right to request additional documentation to support an employee's request and/or need for this leave.

I certify that all information I am providing on this form is true and accurate. If it is later determined that the information provided was not true or accurate, I may be subject to repayment of sick leave monies.

Signature _____ **Date** _____

FOR OFFICE USE ONLY:

Method of Receipt: _____

Eligible: Yes _____ No _____

If No, reason: _____

_____

_____

RECEIVED

Signature _____ Date _____

Title _____