Maryland
DEPARTMENT OF BUDGET AND MANAGEMENT

Request for Emergency Paid Sick Leave
Families First Coronavirus Response Act (FFCRA)

What is the FFCRA? Effective April 1, 2020 through December 31, 2020, Congress has passed new legislation designed to help employees who are unable to work or telework due to the COVID-19 outbreak. The law contains two main components, each with different eligibility requirements and qualifying reasons for taking leave. Detailed information about FFCRA and benefits available to State employees can be found here.

Emergency Paid Sick Leave (EPSL) may only be taken if an employee qualifies for one of the six qualifying conditions (listed below).

If the leave is for #1-3 below, the leave will be paid at your regular rate of pay. If the leave is for reasons #4-6 below, the leave will be paid at 2/3 your regular rate of pay.

Leave under EPSL is available to be used from April 1, 2020 through December 31, 2020. Full time employees are eligible for up to 80 hours of EPSL for a qualifying reason. Part time employees will receive prorated hours based on the number of hours the employee is normally scheduled to work over a two-week period. Requests will be reviewed and eligibility determined per FFCRA.

Request for Emergency Paid Sick Leave (EPSL)

Employee to Complete *(Please Save This Form Prior to Filling Out)*

Employee Name		**Job Classification**	
W#		**Agency/Department**	
Email Address		**Phone #**	
Start Date of Leave		**Type of Leave Requested** ☐ Continuous leave ☐ Intermittent Leave (Only with supervisor agreement)	
End Date of Leave			
If intermittent, please describe the proposed schedule:			

Eligibility: As of April 1, 2020, all regular, contractual, and temporary State employees are eligible for two weeks of paid sick time for specified reasons related to COVID-19.

Qualifying Reasons for EPSL (select all that apply):

☐ I am **unable to work, or telework**, and have a need for leave because:

Qualifying Reason #1

☐ I am subject to a federal, State, or local quarantine or isolation order related to COVID-19.	
Provide the date and issuing authority of the order.	
Date of Order:	
Issuing authority:	

Qualifying Reason #2

☐ I have been advised by a health care provider to self-quarantine related to COVID-19.	
Provide the name, phone #, and address of the health care provider who advised.	
Health Care Provider Name	
Health Care Provider Phone #	
Health Care Provider Address	

Qualifying Reason #3

☐ I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.	
Provide the name, phone #, and address of the health care provider from whom you are seeking medical diagnosis.	
Health Care Provider Name	
Health Care Provider Phone #	
Health Care Provider Address	

Qualifying Reason #4

☐ I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2).	
Provide the name of the individual and relationship	
Name of Individual	
Relationship	

Qualifying Reason #5

☐ I am caring for a son or daughter's whose school or place of care is closed (or child care provider unavailable) for reasons related to COVID-19.

☐ I certify (select the criteria that applies):

☐ My child (or children) is/are under 18 years of age; or

☐ My child (or children) is/are 18 years of age or older and incapable of self-care because of a mental or physical disability

Name of Child	**Relationship**	**Age**	**Older than 14?**
			☐
			☐
			☐
			☐
			☐

For any child over the age of 14, please state the special circumstances requiring care:

_____

Provide the name of school(s) or place(s) of care, or child care provider(s), which are closed or unavailable due to COVID-19 reasons

Name of School, Place of Care, or Child Care Provider	**Phone #**	**Address** *(if care is provided at home, put home address)*

Qualifying Reason #6

☐ I am experiencing any other substantially-similar condition specified by the Secretary of Health and Human Services, in consultation with the Secretaries of Labor and Treasury.
Describe your condition.

Please Provide a Brief Description of Your Circumstances As They Relate To Your Qualifying Reason for EPSL:

_____

Acknowledgments

☐ I understand that by submitting this request, I represent that I am unable to work or telework due to the reason identified above.

☐ If requesting EPSL leave under Qualifying Reason #5, **I certify that no other person will be providing care for the child (or children) during the period being requested.**

☐ I understand I must submit the required information to my supervisor before my leave begins wherever possible. In cases where this is not possible, I understand that my request with information required must be submitted as soon as practicable.

☐ I am also requesting approval for benefits under Expanded Family and Medical Leave Act (FMLA) provisions under FFCRA.

_____ _____

Employee Signature **Date**

To be completed by Human Resources:

☐ Approved ☐ Not approved

Effective Date		End Date	
Pay Code			
# of Hours Requested		**# Hours Available**	
Employee Rate of Pay	☐Full Rate	☐2/3 Rate	
Expanded FMLA Requested or Required?	☐Yes ☐No	If Yes, # of Hours FMLA Available	