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|  | **REQUEST FOR EMERGENCY PAID SICK LEAVE (EPSL) FOR**  **EMERGENCY RESPONDERS AND HEALTH CARE PROVIDERS**  State Form 56942 (R2 / 9-20)  STATE PERSONNEL DEPARTMENT | | | | | | | | | |
| *INSTRUCTIONS: Complete and submit form to your Human Resources (HR) Representative and your Supervisor.* | | | | | | | | | | |
| Name of employee | | | | | | | | People Soft identification number | | |
| Agency | | | | | | | | | | |
| Telephone number  (     ) | | | | E-mail address | | | | | | |
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| I certify the following information is true and accurate: *(Check appropriate boxes.)*  I am a full-time employee, or  I am a part-time, intermittent, or temporary employee.   * In the past six (6) months, I have been regularly assigned to work       hours per pay period.   And I am designated as an **emergency responder or health care provider**, during the COVID-19 pandemic, and am using EPSL for a legal  COVID-19 quarantine to which I am personally subject under (a) or personal COVID-19 illness under (b) or (c).  I am **unable** to work remotely or onsite and need up to 80 hours (full-time employees) continuous EPSL for one or more of the following reasons:  **(a)** I am personally subject to a Federal, State, or local quarantine or isolation order related to COVID–19   * e.g., I am required to quarantine myself after travel or residing with someone confirmed or presumed positive for COVID-19.   **Duration of Order:       days**   * A “Stay at Home” order issued by Federal, State, or Local authorities is not sufficient to qualify for this leave.   **(b)** I have been advised by a health care provider to self-quarantine due to concerns related to COVID–19.  **(c)** I am experiencing symptoms of COVID–19 and seeking a medical diagnosis.  Under (c) I acknowledge I must remain off work until I meet **BOTH** criteria below:   * at least twenty-four (24) hours have passed since recovery defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath) **and** * at least ten (10) days have passed since symptoms first appeared or I was last in the workplace whichever occurred later.   I am **able** to work **remotely** under (a) or (b) above, but not for the total number of hours in my assigned work schedule.  I acknowledge I may be required to work remotely during hours outside my previous work schedule.  I propose the following schedule of work and/or leave. I understand my schedule will not be final until approved by my supervisor, and if work is  available and I have the capability to perform that work remotely, then leave is not available for those work hours.  Total work hours per week       proposed. Total leave hours per week       requested. | | | | | | | | | | |
|  | | **Sunday** | **Monday** | | **Tuesday** | **Wednesday** | **Thursday** | | **Friday** | **Saturday** |
| **Work** | |  |  | |  |  |  | |  |  |
| **Leave** | |  |  | |  |  |  | |  |  |
| **I will complete my timesheet in accordance with instructions and approvals below.**  I acknowledge this paid leave is capped at $511 daily and $5,110 in the aggregate; therefore, if my full salary is above those caps, I may  augment using available accrued leave or earned comp time.  I intend to augment EPSL using the following leaves in the stated order:        Sick Leave – SICK       Personal Leave – PER        Vacation Leave – VAC       Earned Comp Time Used – CTKN  I choose NOT to apply any other leaves and will receive pay (up to $511 daily and $5,110 total) using EPSL only.  NOTE: Due to the complicated calculations required for determining amounts of leave necessary to augment to full pay, timesheets and leave balances may be adjusted by payroll staff.  *See* [*Instructions for Recording Time in Time and Labor for EFML and EPSL*](https://www.in.gov/spd/files/Recording%20Time%20in%20PeopleSoft_UPDATED_4-1-20.pdf)*.* | | | | | | | | | | |
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| Begin date *(month, day, year)* | | | | | | Estimated end date *(month, day, year)* \* | | | | |
| Signature of employee *(A typed signature is sufficient.)* | | | | | | | | Date of request *(month, day, year)* | | |

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| ***This section to be completed by an HR representative in consultation with the supervisor.*** | | |
| Number of hours EPSL approved | | Date of approval *(month, day, year)* |
| Name of approver | Title of approver | |