EMERGENCY PAID SICK LEAVE (EPSL) REQUEST
TO CARE FOR MY SUBSTANTIALLY SIMILAR CONDITION

In accordance with the Families First Coronavirus Response Act (U. S. House Bill 6201), #6

Employee Name _____ Department _____

I am unable to work or telework because I am experiences symptoms that are not COVID-19 but are substantially similar as specified by the US Department of Health and Human Services.

I have worked for the City of Portsmouth for at least 30 days and request a leave of absence continuously for _____ weeks, starting on _____ and ending on or about _____. I will provide a written update should my condition change.

I understand I am eligible for any unused portion of my maximum two weeks' *Emergency Paid Sick Leave*, payable at two-thirds my regular rate of pay (up to the maximum allowed of $200/day, to the maximum aggregate total of $2,000).

I have notified the following appropriate member/s of my department's management team of my need for leave:

Please list Names:_____

My out-of-work contact information is: Email_____ Telephone_____

I hereby certify that the information given above is true and correct to the best of my knowledge. I understand that if this information is not received by Human Resources within the allowed timeframe according to the federal FMLA guidelines, my leave will be considered unauthorized. I understand I will need to notify my department and/or Human Resources immediately if any of the information above should change.

_____

Employee Signature Date

Please save this form to your device, then attach with the proof requested, to your email addressed to kaharper@cityofportsmouth.com