

Arizona Supreme Court

Notification of Need for Leave for COVID-19 Reasons

NOTE: Please submit this form to Human Resources as soon as possible when you become aware that you need one or both of these types of leave.

Employee Name: _____

Employee Email Address (personal preferred): _____

EIN: _____ Date of Request: _____

I request leave from (Date): _____ through (Date): _____
(if unknown, say unknown)

Leave is Requested for the Following Reason(s) (Check One or Both as applicable):

_____ **Emergency Paid Sick Leave** of up to 80 hours because I am unable to work or telework for a reason related to COVID-19.

Place an 'X' next to all reasons that apply to your request for Emergency Paid Sick Leave:

	(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 quarantine or isolation order is: _____.
	(2) I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. The name of the health care provider who advised me to self-quarantine for COVID-19 related reasons is: _____.
	(3) I am experiencing symptoms of COVID-19 and seeking a medical diagnosis or pending testing. The name of the health care provider through whom I am seeking a diagnosis or received a test is: _____.
	(4) I am caring for an individual who is subject to quarantine under number 1 or 2 above. <i>The government entity that issued the quarantine or isolation order to which the individual is subject is: _____; OR the name of the health care provider who advised the individual to self-quarantine is: _____; and the relationship of the individual to me is (circle one) PARENT; SPOUSE; CHILD; ROOMMATE; OTHER: _____.</i>
	(5) I am caring for my son or daughter (including a foster child or stepchild) due to their school or childcare facility or provider being closed or unavailable, due to COVID-19 precautions. Please provide the information requested below that relates to these child/ren. Note: If you check this item, and you have been employed by the State for the past 30 calendar days, please also check Emergency Family and Medical Leave Expansion Act Leave below.

_____ **Emergency Family and Medical Leave Expansion Act Leave.** I need leave to care for my child/ren because the school or place of care has been closed, or the child care provider of my child/ren is unavailable, due to a public health emergency relating to the Coronavirus (COVID-19). I have been employed by the State of Arizona for at least 30 calendar days (i.e., I have been or will have been a State employee the 30 calendar days immediately prior to the day my requested leave is to begin).

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If you checked Item 4 and/or 5 on Page 1, please provide the following information:

Name(s) of child/ren: _____

Name of the school, place of care, or child care provider that closed or became unavailable due to

COVID-19 reasons: _____

Please initial:

_____ I represent that no other suitable person is available to care for the child/ren during the period of the requested leave.

IMPORTANT: While on Emergency Paid Sick Leave to care for another individual, or while caring for your child/ren because their school or care provider is closed or unavailable, you are entitled to only 2/3's of your regular rate of pay, up to a maximum of \$200 per day. You may elect to use paid leave from your accrued leave balances to supplement the remaining 1/3 of your regular pay. Please indicate whether you would like to supplement your pay while on Emergency Paid Sick Leave with paid leave below.

Similarly, while on Emergency FMLA Expansion Leave to care for your child/ren because their school or care provider is closed or unavailable, you are entitled to only 2/3's of your regular rate of pay, up to a maximum of \$200 per day. You may elect to use paid leave from your accrued leave balances to supplement the remaining 1/3 of your regular pay. Please indicate whether you would like to supplement your pay while on Emergency FMLA Expansion Leave with paid leave below.

If you elect to supplement your pay with paid leave balances, your leave balances will be deducted in an amount necessary to bring your pay up to your normal earnings level, but not greater.

_____ I would like to supplement my pay with paid leave from my applicable balances

_____ I DO NOT wish to supplement my pay with paid leave from my applicable balances

Note: If you need leave for the birth of a child, your own serious health condition, to care for a family member who has a serious health condition or another qualifying reason under the FMLA, please contact your Human Resources before submitting this form.

Employee Signature (Electronic Signature Accepted)

Date

For HR Completion Only:

_____ Date Received

_____ Date Leave Pkg Sent to Employee

Date of first day of absence _____

Form Used: _____