State of Delaware
Department of Human Resources

COVID-19 FEDERAL EMERGENCY PAID SICK LEAVE (FPSL) REQUEST FORM	
COVID-19 FPSL Temporary Statewide Form	**Authority: Director of Office of Management and Budget's authority to manage expenditures for the continuity of state government operations and with the approval of the General Assembly; Merit Rule 5.7**
Effective: January 1, 2022	**Supersedes: September 19, 2021 FPSL Form**

Employee Name: _____ Date: _____

Employee Title: _____ Date of Hire: _____

Department/Division: _____

I am a (choose one): ☐ Full-Time ☐ Part-Time ☐ Casual/Seasonal Employee

Requested Leave Start Date: _____ End Date: _____

The FFCRA provides emergency paid sick leave if an employee meets one of the qualifying reasons listed below. If the leave is for reasons #1 - #3 and ARPA qualifying reasons #7 - #9, the leave will be paid at 100% of the employee's regular earnings. If the leave is for reasons #4 - #6, the leave will be paid at two-thirds of the employee's regular earnings. **If an employee has a remaining balance of SPEL, the SPEL shall be used concurrently with any remaining FPSL.**

Due to COVID-19, I am unable to work (or telecommute) and requesting Federal Emergency Paid Sick Leave (FPSL) due to (choose qualifying reasons(s) for FPSL):

Qualifying Reason 1:

☐ I am a subject to a federal, state or local quarantine or isolation order related to COVID-19. Provide the requested information below:

Date of Order: _____ Order Attached: ☐ Yes ☐ No ☐ To follow: _____ (Date)

Healthcare Provider Name: _____

Healthcare Provider Address: _____

Healthcare Provider Phone Number: _____

Qualifying Reason 2:

☐ I have been advised by a healthcare provider to self-quarantine related to COVID-19. Provide the requested information below:

Healthcare Provider Name: _____

Healthcare Provider Address: _____

Healthcare Provider Phone Number: _____

Qualifying Reason 3:

☐ I am experiencing COVID-19 symptoms and am seeking medical diagnosis. Provide the requested information below:

Healthcare Provider Name: _____

Healthcare Provider Address: _____

Healthcare Provider Phone Number: _____

Qualifying Reason 4:

☐ I am caring for an ill individual subject to an order described in (1) or self-quarantine as described in (2).
Provide the requested information below:

Name of Individual: _____

Address of Individual: _____

Relationship to Individual: _____

Qualifying Reason 5:

☐ I am caring for a child (under the age of 18 years old) whose school or childcare is closed or otherwise unavailable due to COVID-19.
I certify that (select the criteria that applies):

☐ I am the parent of a child (or children) who is/are under 18 years of age; or

☐ I am the parent of a child (or children) 18 years of age or older and incapable of self-care because of a mental or physical disability.

Name and address of the school(s), place(s) of care, or childcare provider(s), which are closed or unavailable due to COVID-19.

_____

_____

_____

_____

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:

_____

_____

Qualifying Reason 7:

☐ I have been exposed to COVID-19 symptoms and am seeking or awaiting the results of a test for COVID-19 or my employer has requested such test or diagnosis:
Provide requested information below:

Date of Test or Diagnosis: _____

Estimated Date of Test/Diagnosis Results: _____

Testing Site Address: _____

Qualifying Reason 8:

☐ I am obtaining the COVID-19 vaccination.
Provide the requested information below:

☐ 1st dose of COVID-19 vaccine ☐ 2nddose of COVID-19 vaccine ☐ COVID-19 booster shot

Date(s) of COVID-19 Vaccine Appointment: _____

Appointment Location: _____

Qualifying Reason 9

☐ I am recovering from an injury, disability, illness, or condition related to the COVID-19 vaccination.
Provide the requested information below:

☐ 1st dose of COVID-19 vaccine ☐ 2nd dose of COVID-19 vaccine ☐ COVID-19 booster shot

Date(s) of COVID-19 Vaccine Appointment: _____

Appointment Location: _____

Describe your condition: _____

_____

FPSL is paid at two-thirds of an employee's regular earnings for qualifying reasons #4 - #6 and may be taken intermittently and in hours, with agency approval. Employees shall cover the remaining 1/3 of their salary in one of the following ways:

_____ (# hours) **Unused** State Paid Emergency Leave (SPEL) _____ (# hours) Accrued Sick Leave

_____ (# hours) Accrued Annual Leave _____ (# hours) Compensatory Time

Time off work is expected to be for (choose one):

☐ A continuous period of time ☐ An intermittent period of time

If requesting intermittent leave, indicate the days and hours needed per pay period. If additional space is needed, please use a separate piece of paper.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**

☐ I have read and understand the attached COVID-19 Leave Policy and agree to the duties, obligations, responsibilities and conditions to request leave therein. I attest that the above information is accurate and complete. I understand that management may, at any time, change any or all the conditions under which I am permitted to use leave, or withdraw permission temporarily without cause or explanation.

☐ By using this form, the parties acknowledge their agreement to conduct transactions by electronic means. A party's electronic signature for purposes of the Uniform Electronic Transactions Act, 6 *Del. C.* Ch. 12A, may be provided by checking the box as indicated, electronic initials or name, or e-mail confirmation.

_____ _____

Employee Signature and Date Employee Supervisor Signature and Date

_____

Agency Human Resources Signature and Date ☐ Approved ☐ Denied

EXCEPTIONS/EXCLUSIONS:

Employees that fall into the categories of emergency responders and health care providers are eligible for leave if they are quarantined or ill due to COVID-19. However, these employees are not eligible to utilize leave for other reasons related to COVID-19 such as leave to care for ill or quarantined family members or for childcare purposes.

This policy is not intended to create any individual right or cause of action not already existing and recognized under State and Federal law.