



# Altmar-Parish-Williamstown Central School District

## District Office



639 County Route 22 • Parish, NY 13131



(315) 625-5250



(315) 625-7952



www.apwschools.org

### Employee Request for Emergency Paid Sick Leave and/or Emergency Family and Medical Leave Act (April 1, 2020-December 31, 2020)

Please complete the below request for leave pursuant to the Emergency Paid Sick Leave (EPSL) and/or the Emergency Family and Medical Leave Act Expansion (E-FMLA) under the Families First Coronavirus Response Act (FFCRA), and return to the District Clerk in the District Office, as soon as possible.

Employee Name (Print): \_\_\_\_\_

This is a (choose one):  New request for leave  Request for an extension of leave

Anticipated Start Date of Leave: \_\_\_\_\_ Anticipated End Date of Leave: \_\_\_\_\_

I. Reason for Leave (check all applicable)

I am unable to work (or telework were permissible) for the following reasons:

- 1.) I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
- 2.) I have been advised by a health care provider to self-quarantine related to COVID-19;
- 3.) I am experiencing COVID-19 symptoms and seeking a medical diagnosis;
- 4.) I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2); or
- 5.) I am caring for a child under 18 whose school or place of care is closed (or child care provider is unavailable) for reasons related to COVID-19.

For Reasons 1-3: 100% pay up to daily maximum of \$511/day for up to 2 weeks

For Reason 4: 2/3<sup>rd</sup> pay up to daily maximum of \$200/day for up to 2 weeks

For Reason 5: 2/3<sup>rd</sup> pay up to daily maximum of \$200/day for up to 12 weeks

- A. If you selected reasons 1 or 2 above, please provide the name of the governmental entity ordering the quarantine or the name of the health care professional advising self-quarantine. Please also attach a copy of any quarantine order or correspondence from the health care professional advising self-quarantine.

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B. If you selected reason 3 above, paid leave is available only for the time you are unable to work while you are taking affirmative steps to obtain a test and medical diagnosis. By signing this application form, you are certifying and representing that you will obtain a COVID-19 test and medical diagnosis as expeditiously as possible, and upon receipt of such diagnosis, you will promptly advise of the results, and of any need for continued leave, or your ability to return to work.

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C. If you selected reason 4 above, please provide the name of the governmental entity ordering the quarantine or the name of the health care professional advising self-quarantine, as well as the name of the person for whom you are providing care and their relationship to you. Please also attach a copy of the quarantine order or correspondence from the health care professional advising self-quarantine.

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D. If you selected reason 5 above, please provide the following information:  
Name(s) and Age(s) of your Child/Children:

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The Name of the School/Place of Care that Closed:

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Please also attach documentation indicating that the school or place of care has closed. Examples of acceptable documentation include a notice that has been posted on a government, school, or day care website; a notice published in a newspaper; or an email or a letter from an official of the school, place of care, or child care provider.

Further, by providing the information above and signing this application form, you are certifying and representing that no other person will be providing care for your child or children during the period for which you are receiving leave pursuant to reason 5 above and you will be unable to work (or where permitted telework) in the period of requested leave.

II. Type of Leave (choose one).

**I am requesting one of the following:**  Continuous leave **or**  Intermittent leave

If your request for leave is intermittent, please describe the timing and frequency of your intermittent leave request: (attaching APW CSD Instructional Calendar 2020-2021 with dates circled is acceptable)

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A request for intermittent leave will be considered but may be denied by the District in its discretion where intermittent leave would substantially impair the District’s operations and/or the District’s ability to provide instruction.

III. Certifications

I certify that the above information is accurate and complete:

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

IV. Communications

1. Please discuss this leave with your immediate supervisor. Once you and your supervisor have come to a determination, supervisor’s signature is required before submitting to District Office.

Supervisor’s Comments:

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Supervisor’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Submit form to District Office for processing. You will be notified within 72 hours of the decision. Any questions or concerns should be directed to Cheryl Emory at 315-625-5251 or via email at [cemory@apw.cnyric.org](mailto:cemory@apw.cnyric.org).

Upon approval of your designated leave, you will be responsible for making sure to update WinCap Web with your approved time off. Any changes to your approved leave must be communicated to your immediate supervisor and the District Office immediately.

Superintendent’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_