



TOWN OF ELLINGTON

55 MAIN STREET – PO BOX 187
ELLINGTON, CONNECTICUT 06029-0187
www.ellington-ct.gov

Request for Emergency Paid Sick Leave due to the COVID-19 Coronavirus

Employee Name (print clearly): _____

Department: _____ Manager: _____

Requested Leave Start Date: _____ End Date: _____

The amount of emergency paid sick leave being requested is _____ hours.

[Optional: I wish to take intermittent leave for reason E below, during the following days and hours:]

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

I am requesting this emergency paid sick leave due to my inability to work (or telework) because (check the appropriate reason below):

- A) I am subject to a federal, state, or local quarantine or isolation order related to COVID–19.
- 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.
- D) I am caring for an individual who is subject to either A or B above.
- E) I am caring for my child whose primary or secondary school or place of care has been closed, or my childcare provider is unavailable due to COVID–19 precautions; and,
 - I attest that no other suitable person is available to care for my child during the requested period of leave
 - I attest special circumstances exist requiring my need for leave to care for a child ages 15-17.
- F) I am experiencing another substantially similar condition specified by the US Secretary of Health and Human Services.
 - I have attached documentation supporting my need for leave.

Employee Signature _____ Date _____

Manager Signature _____ Date _____

First Selectman Signature _____ Date _____



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Employee Statement Supporting Leave Due to COVID-19

I, _____, provide the following information in support of my request for emergency paid sick leave (complete all that apply):

Leave due to a government-issued quarantine or isolation order

Name of the issuing government agency for the quarantine or isolation order:

_____ Effective dates of the order: _____

Leave due to a health care provider's advice to self-quarantine

Name of the health care provider advising me or the individual I am caring for to self-quarantine:

_____ Written documentation is available and attached: Yes No

Name and relation of the individual who I am needed to care for:

Name: _____ Relation: _____

Leave due to a school or place of child care closed due to COVID-19

Name of school or place of care: _____

Name of child caregiver unavailable due to concerns related to COVID-19: _____

Name and age of child or children I am needed to care for:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

No other suitable person is available to care for my child for the requested leave period due to:

The special circumstances requiring my need for leave to care for a child ages 15-17 are:

Leave due to a substantially similar condition specified by the secretary of health and human services

Provide details regarding the need for this leave:

I attest that the above information is accurate and complete. I understand falsification of any information given may lead to disciplinary action.

Employee Signature: _____ Date: _____

Distribution after approval: Department Head Employee Medical File (original) Payroll