



## **COVID-19 EMORY PAID LEAVE REQUEST FORM**

I, \_\_\_\_\_, hereby attest I am unable to return to work on campus on the following dates \_\_\_\_\_

**(please specify period) for the following reasons: (select all that apply):**

\_\_\_\_\_ I have been diagnosed with the COVID-19 virus (**Documentation from a medical provider or approved medical facility has been faxed to 404-712-5205, along with this form**).

\_\_\_\_\_ I am subject to a federal, state, or local quarantine or isolation order related to COVID-19 (**Documentation from a medical provider or approved medical facility has been faxed to 404-712-5205, along with this form**).

\_\_\_\_\_ I have been advised by a medical provider or facility to self-quarantine due to concerns related to COVID-19 (**Documentation from a medical provider or approved medical facility has been faxed to 404-712-5205, along with this form**).

\_\_\_\_\_ I am caring for immediate family members who are subject to a federal, state, or local quarantine or isolation order related to COVID-19 (**Documentation from a medical provider or approved medical facility has been faxed to 404-712-5205, along with this form**).

**I understand that my request will be reviewed, and if remote work and/or paid leave is not available, I may be placed in an unpaid status.**

**Please provide any other relevant information below:**

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\*I will promptly notify my manager if there is any substantial change in these circumstances.

**Employee Name:** \_\_\_\_\_

**Employee Signature:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_