|  |  |  |
| --- | --- | --- |
| Employee Name | Employee ID | Date Submitted |

Employee Notice for Use of Paid Sick Leave

Please fill out and return this form to **[insert contact]** by the date specified in the table directly below.

|  |  |  |
| --- | --- | --- |
| **Reason for Paid Sick Leave Use** | **Foreseeable or Unforeseeable?** | **Form Required By** |
| To care for yourself or a family member, or because your child’s school or place of care is closed by order of a public official for any health-related reason. | Foreseeable | Please complete this form at least **[not more than 10]** days,or as early as practicable, before the first day paid sick leave is used. |
| To care for yourself or a family member, or because your child’s school or place of care is closed by order of a public official for any health-related reason. | Unforeseeable | Please complete this form upon your return from using paid sick leave.  |
| To address issues related to you or your family member being a victim of domestic violence, sexual assault, or stalking. | Foreseeable | Please complete this form as soon as possible before using paid sick leave for such reason. |
| To address issues related to you or your family member being a victim of domestic violence, sexual assault, or stalking. | Unforeseeable | Please complete this form upon your return from using paid sick leave.  |

I am providing notification of my use of paid sick leave for the following date(s) and time(s):

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date | Shift Type | Start Time | End Time | Total Hours  |
|  | [ ]  Full [ ]  Partial | [ ]  am [ ]  pm | [ ]  am [ ]  pm |  |
|  | [ ]  Full [ ]  Partial | [ ]  am [ ]  pm | [ ]  am [ ]  pm |  |
|  | [ ]  Full [ ]  Partial | [ ]  am [ ]  pm | [ ]  am [ ]  pm |  |
|  | [ ]  Full [ ]  Partial | [ ]  am [ ]  pm | [ ]  am [ ]  pm |  |
|  | [ ]  Full [ ]  Partial | [ ]  am [ ]  pm | [ ]  am [ ]  pm |  |

[ ]  Documentation is attached (if necessary) for use of paid sick leave for more than three (3) consecutive days for which I was required to work.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Employee’s Signature |  | Date |

**To Be Completed to the Employer**

|  |  |
| --- | --- |
| Paid Sick Leave Hours Used: |  |
| Remaining Balance:  |  |
| Comments:  |
|  |
|  |