FERRIS STATE UNIVERSITY

OFFICE OF SCHOLARSHIPS AND FINANCIAL AID
STUDENT EMPLOYMENT OFFICE

Ferris State University
Office of Scholarships & Financial Aid
Student Employment

1201 S. State St.
Big Rapids, MI 49307
Phone: (231) 591-2110
Email: finaid@ferris.edu
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Certification for Emergency Paid Sick Leave Act (EPSLA)

The EPSLA provides emergency sick leave to any employee with a qualifying need, regardless of length of employment. Qualified Part-Time employees are eligible for up to the average number of hours they work over a two-week period. This Act takes effect on April 2, 2020 and will remain in effect until December 31, 2020.

Employer name and contact: Ferris State University – Student Employment
Email: Stuempl@ferris.edu

Your Name: _____ _____ _____
First Middle Last

Banner ID: _____

Your Title: _____

Your Hire Date: _____

Date to start your leave: _____

Expected return to work date: _____

Supervisor: _____

(Continued on second page)

Please put a check mark below for your Qualifying Purpose:

_____ I am subject to a federal, state or local quarantine or isolation order related to COVID-19.
**Required: Please include the name of the government entity: _____.

_____ I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
** Required: Please include the name of the Health Care Professional advising quarantine:
_____.

_____ I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

_____ I am caring for an individual who is subject to a quarantine or isolation order related to COVID-19 or who has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

_____ I am experiencing other substantially similar condition(s) specified by the Secretary of Health and Human Services in consultation with the Secretary of the treasury and Secretary of Labor.

_____ I am caring for my son or daughter whose school or place of care has been closed, or their child-care provider is unavailable due to COVID-19 precautions. Please list the child's name and age below.

First	Last	Age	School or Care Provider's Name
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I hereby certify that I meet the requirements for the Emergency Paid Sick Leave Act.

_____ _____
Signature Date