PROGENY ACADEMY
MN ESST TIME OFF REQUEST FORM

In accordance with PACS' MN ESST Time Off Policy, please complete this time off request form and note that you must complete all details

Name: _____ **Date of Time Off:** _____

Amount of Time Off (Full day, half day, # of hours, etc.): _____

I am requesting time off for one of the following MN ESST reasons and I attest that I am using Safe and Sick Leave for a legitimate qualifying purpose:

_____ An absence resulting from my own mental or physical illness, injury, or health condition; to accommodate the employee's need for medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition; or an employee's need for preventive medical care;

_____ To allow me to provide care for a family member with a mental or physical illness, injury, or health condition; care for a family member who needs medical diagnosis, care, or treatment of a mental or physical illness, injury, or health condition; or care for a family member who needs preventive medical care.

_____ An absence due to domestic abuse, sexual assault, or stalking

_____ For Myself

_____ For a Family member (as defined below)

Please select one of the following ESST qualifying reasons:

_____ Seek medical attention related to physical or psychological injury or disability caused by domestic abuse, sexual assault, or stalking;

_____ Obtain services from a victim-services organization;

_____ Obtain psychological or other counseling;

_____ Seek relocation due to domestic abuse, sexual assault, or stalking; or

_____ Seek legal advice or take legal action, including preparing for or participating in any civil or criminal legal proceeding related to or resulting from domestic abuse, sexual assault, or stalking.

_____ I have been directed by a health authority or health care professional that _____ I or a _____family member is at risk of infecting others with a communicable disease. ***(Select if for yourself or a family member.)***

_____ The closure of my place of business by order of a public official to limit exposure to an infectious agent, biological toxin or hazardous material or other public health emergency.

_____ To accommodate the need to care for a family member whose school or place of care has been closed by order of a public official to limit exposure to an infectious agent, biological toxin or hazardous material or other public health emergency.

_____ To accommodate my need to care for a family member whose school or place of care has been closed due to inclement weather, loss of power, loss of heating, loss of water, or other unexpected closure. _____ Absence due to business closure for the employee or for a family member's schools, day care closure due to weather or a public emergency.

I am taking time away from work for the following family members:

_____ *child(ren) including foster child, adult child, legal ward, child for whom the employee is legal guardian or child to whom the employee stands or stood in loco parentis (in place of parent)* _____ *parents, parents-in-law, step-parents, foster parent*

_____ *spouses, registered domestic partners*

_____ *grandchildren, foster grand children, step-grandchild, grandparents,*

step-grandparent, _____ siblings, step-sibling, sibling in-law
_____ wards, niece, nephew
_____ a sibling of the parents of an employee (Aunt or Uncle)
_____ any child to whom the employee stand(s) in place of a parent
_____ any parent who stood in place of a parent for the employee
_____ other individuals related by blood or affinity
_____ including any of the family members listed above for an employee's spouse or registered domestic partner
_____ up to one individual annually designated by the employee
I designate the following named individual:_____ On this date:
_____

I am aware that COMPANY may require documentation if an employee misses more than three consecutive days.

I am aware that I have 14 calendar days to provide the company with written documentation if it is requested. If the employee or family member did not receive services from a health care provider, then I am aware that I will provide a written statement indicating the employee is using Vacation/PTO for a MN ESST leave qualifying purpose.

I am aware that use of PTO/Vacation and/or MN ESST leave may run concurrently with any eligible FMLA or other protected leave.

I am aware that MN ESST must be paid at the same hourly rate employees earn from employment and that I may use MN ESST leave for all or part of a shift.

I am aware that employees are not required to seek or find a replacement for their shift to use MN ESST leave.

I am aware that is against the law for an employer to retaliate, or to take negative action, against an employee for using or requesting earned sick and safe time or otherwise exercising their earned sick and safe time rights under the law. If an employee believes they have been retaliated against or improperly denied earned sick and safe time, they can file a complaint with the Minnesota Department of Labor and Industry. They can also file a civil action in court for earned sick and safe time violations.

Employee Attestation:
I understand that providing false or misleading information regarding the need for any time away or MN ESST leave time requested qualifying event will be grounds for corrective action, up to and including termination of employment.

Signature _____ **Date** _____

SUBMIT COMPLETED FORM TO THE DIRECTOR