HMONG HOME
HEALTH CARE, INC.

Minnesota Earned Sick & Safe Time

PAID LEAVE REQUEST / AGREEMENT

Employee Name: _____ Date: _____

Date of Birth:_____

Date requested and hours per day: _____

Date requested and hours per day: _____

Date requested and hours per day: _____

Total hours requests: _____

I confirm that I am requesting paid time for one of the following reasons:

- my own mental or physical illness, treatment or preventive care;
- the mental or physical illness, treatment or preventive care of my family member;
- an absence due to domestic abuse, sexual assault or stalking of me or my family member;
- closure of an employee's workplace due to weather or public emergency or closure of my family member's school or care facility due to weather or public emergency; and
- when my family member or I is at risk of infecting others with a communicable disease, as determined by a health authority or health care professional.
- making funeral arrangements, attending a funeral service or memorial or addressing financial or legal matters that arise after the death of a family member.

I acknowledge that I have informed the client I work for, and/or their representative, that I will not be (or was not) available to work during this time. I understand that I am requesting paid time leave from my ESST balance and if approved by the HR department, that it will be deducted from my available balance of accrued time. I understand that I may be required to supply supporting documents for this request before approval.

_____

Employee Signature Date

_____

Authorized Signature of Approver (HHHC HR) Date