**Designated Person Request Form (PSL)**

**Name:** _____ **Today's Date (Month/Day/Year):** _____

I, _____ am requesting paid sick leave for diagnosis, care or
(Name of Employee)
treatment of an existing health condition of, or preventive care for, a designated person.

_____ _____
(Name of Designated Person) (Start Date of Paid Sick Leave)

Please note the following:

- You may identify your designated person at the time you request paid sick leave.
- You are limited to ***one*** **designated person per 12-month period** for paid sick leave.

*By signing below, I am confirming my designated person, and acknowledging that I am limited to one designated person in a 12-month period. If signing electronically, please type your full name, followed by "e-signed."*

_____ _____
Employee's Signature Date

**Administrative Use Only**

☐ **Approved** ☐ **Denied**

**Additional Notes:**

_____
_____
_____
_____