Request for Supplemental Paid Sick Leave

2021 COVID-19 Supplemental Paid Sick Leave is the result of Senate Bill 95 and is effective March 29, 2021. Supplemental Paid Sick Leave under SB95 provides up to 80 hours of COVID-19 related sick leave from January 1, 2021 through September 30, 2021, immediately upon an oral or written request to their employer. If an employee took leave for the reasons below prior to March 29, 2021, the employee should make an oral or written request to the employer for retroactive use of the leave.

Please complete the following form if you are requesting to take Supplemental Paid Sick Leave. The information requested in this form must be submitted as soon as practicable, when the need for leave is known after the need for leave arises.

Employee Name: _____

Date of Request:_____

SECTION 1 (required)

I am requesting Supplemental Paid Sick Leave because I am unable to work because of the following reason:

_____ Caring for Yourself: The employee is subject to quarantine or isolation period related to COVID-19 as defined by an order or guidelines of the California Department of Public Health, the federal Centers for Disease Control and Prevention, or a local health officer with jurisdiction over the workplace.

_____ Experiencing COVID-19 symptoms and seeking a medical diagnosis.

_____ Have been advised by a healthcare provider to quarantine.

The name of the health care provider who has advised the individual to self-quarantine _____.

_____ Vaccine-Related: The covered employee is attending a vaccine appointment or cannot work or telework due to vaccine-related symptoms.

_____ Caring for a Family Member: The covered employee is caring for a family member who is subject to a COVID-19 quarantine or isolation period or has been advised by a healthcare provided to quarantine due to COVID-19.

COVID-19: Request for Supplemental Paid Sick Leave

_____ Caring for a child whose school or place of care is closed or unavailable due to COVID-19 on the premises.

The name of my son(s) or daughter(s) whom I am caring for is: _____
_____

The name of my son or daughter's school, place of care, or childcare provider that is closed or unavailable is:
_____.

The date of the end of school curriculum or the last day of class, for my son or daughter's school:
_____.

_____
Employee Signature

SECTION 2 (required)

I am requesting Supplemental Paid Sick Leave begin on _____, 2021.

I expect to use Supplemental Paid Sick Leave until _____, 2021.

SECTION 2A (optional)

I am requesting to take Supplemental Paid Sick Leave on an intermittent basis:

_____ Yes _____ No

I am requesting to take Supplemental Paid Sick Leave on an intermittent basis as follows and for the following reason(s):

_____

_____.

COVID-19: Request for Supplemental Paid Sick Leave

SECTION 3 (required)

I certify that the above information is true and correct.

_____ _____

Employee Signature Date

COVID-19: Request for Supplemental Paid Sick Leave

FOR HUMAN RESOURCES USE:

THIS COMPLETED FORM AND ANY OTHER DOCUMENTATION RELATED TO THE REQUEST FOR SUPPLEMENTAL PAID SICK LEAVE MUST BE RETAINED FOR 4 YEARS REGARDLESS OF WHETHER LEAVE IS GRANTED OR DENIED.

Date: _____

Request for Supplemental Paid Sick Leave Approved: _____ Yes _____ No

Dates of Approved Supplemental Paid Sick Leave: _____

NOTES:

_____

_____

_____

_____

APPROVED BY:

_____
Area Vice President: Name and Title

_____
Area Vice President: Signature

_____
Vice President, Human Resources: Name

_____
Vice President, Human Resources: Signature