Certified
EMPLOYMENT GROUP

2022 COVID-19 SUPPLEMENTAL PAID SICK LEAVE ABSENCE REQUEST

Name:	**Date:**
SS#:	**Client Company Where Assigned:**

To request a COVID-19 related leave of absence, please complete the following request form and submit it to your Certified branch representative as soon as practical.

TO BE COMPLETED BY EMPLOYEE:

I request COVID-19 supplemental paid sick leave beginning ____/____/____ to ____/____/____, using a total of ____ hours. (Please note, if using more than a total of 40 hours – please be sure to checkmark both options 1 & 2)

I am unable to work or telework because:

OPTION 1 – COVID-19 Qualifying Reasons: Hours used _____ (*Up to 40 hours).*

☐ I am 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 *(ex: exposed to COVID-19).*

☐ I have been advised by a healthcare provider to quarantine/isolate due to COVID-19 symptoms and am seeking a medical diagnosis *(ex: waiting on test results).*

☐ I am caring for a family member experiencing symptoms related to COVID-19 or who has been advised to isolate or quarantine, as described above.

☐ I am caring for a child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises.

Vaccine-Related Qualifying Reasons: Hours used _____ (*Up to 24 hours).*

☐ I am attending a vaccine/booster appointment for protection against COVID-19.

☐ I cannot work or telework due to vaccine-related symptoms.

☐ I am attending an appointment for a family member to receive a vaccine/booster for protection against COVID-19.

☐ I am caring for a family member experiencing symptoms related to the vaccine/booster.

OPTION 2 – Positive COVID-19 Test Results: Hours used _____ (*Up to an additional 40 hours).*

You may be required an additional test on or after the fifth day after the initial test was taken.

☐ I tested positive for COVID-19 and require proof of positive test/documentation.

☐ I am providing care for a family member who tested positive for COVID-19 and requires proof of positive test/documentation.

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LEAVES THAT ARE NOT COVID-19 RELATED ARE NOT ELIGIBLE

I understand that I must contact HR and/or my supervisor prior to taking leave and returning to work.

Employee Signature _____ Date _____

TO BE COMPLETED BY CLIENT COMPANY MANAGEMENT:

Notes:

Approved by Supervisor _____ **Date** _____

Disapproved by Supervisor _____ **Date** _____

The completed form will be maintained in a confidential file, separate from your personnel file.