



OFFICE OF HUMAN RESOURCES

COVID-19 SUPPLEMENTAL PAID SICK LEAVE (SPSL) REQUEST FORM

EMPLOYEE INFORMATION:

| | |
|-----------------|----------------------|
| Name: | Department/Division: |
| Classification: | Supervisor: |

LEAVE DATES:

Leave Start Date: ____ / ____ / ____

Leave End Date: ____ / ____ / ____

Have you used any COVID-19 supplemental paid sick leave hours since January 1, 2021*? Yes No; If yes, please identify the dates and corresponding number of hours used:

** COVID-19 Supplemental Paid Sick Leave (SPSL) is available for qualifying leave reasons beginning January 1, 2021, through September 30, 2021. Supplemental paid sick leave used starting January 1, 2021, for qualifying reasons under the now expired Family First Coronavirus Response Act (FFCRA) and Emergency Paid Sick Leave Act (EPSLA), might qualify as an offset that wholly or partially satisfies supplemental paid sick leave under SB95.*

REASON FOR COVID-19 SUPPLEMENTAL PAID SICK LEAVE:

Consistent with the requirements of SB 95, I am requesting COVID-19 Supplemental Paid Sick Leave because I am unable to work or telework because of the following reason(s):

- (1)** I am subject to a quarantine or isolation period related to COVID-19 as defined by the State Department of Public Health, the Centers for Disease Control and Prevention, or a local health officer who has jurisdiction over the workplace.
- (2)** I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. *(Please attach health-care provider's certification).*
- (3)** I am attending an appointment to receive a COVID-19 vaccine.
- (4)** I am experiencing symptoms related to a COVID-19 vaccine.
- (5)** I am experiencing symptoms of COVID-19 and seeking a medical diagnosis. *(Please attach health-care provider's certification).*
- (6)** I am caring for a family member who is subject to a quarantine or isolation period or advised by a health care provider to self-quarantine.

- (7)** 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. Please complete section below:

| Name of Child(ren) | Age | Name of School, Place of Care or Caregiver unavailable due to concerns related to COVID-19: |
|--------------------|-----|---|
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- I confirm that there is no other suitable person to provide care for my child(ren) during the period for which leave is requested, and that if such child(ren) is older than fourteen, special circumstances exist requiring me to provide care. _____ (employee's initials)

PAY WHILE ON LEAVE:

SPSL extends for the duration of the applicable reason(s) described above, not to exceed 80 hours for full-time employees and prorated for part-time employees. COVID-19 SPSL provides up to a statutory cap of \$511 daily and \$5,110 total aggregate. SPSL will be administered in conformance with the requirements of SB 95. The Department of Industrial Relations provides answers to frequently asked questions in regards to this benefit. You can access this informational page at: <https://www.dir.ca.gov/dlse/COVID19Resources/FAQ-for-SPSL-2021.html>

I understand that I will be required to provide timely medical or other certification as a condition of obtaining SPSL, unless the certification cannot practicably be obtained. I understand that it is my obligation to discuss any inability to obtain the requested certification with the representative at the Office of Human Resources that is coordinating my leave.

By submitting this request for SPSL, I certify that all information provided in this request form is true and accurate. I will update my supervisor and Human Resources if my availability for work changes or if my ability to work or telework changes. I understand that, if I am provided SPSL due to childcare obligations for closure of my child's care facility due to COVID-19 on the premises, I am obligated to return to my regular work schedule (whether part-time or full-time) if my childcare obligations cease. If my childcare obligation need is reduced, I will contact my supervisor to discuss options. I understand that my request (if approved) will be processed for the applicable dates of such leave and paid on the closest possible pay period based on when the form is completed by me and received by Human Resources.

Employee Signature

Date