REQUEST FOR LEAVE OF ABSENCE
RELATED TO COVID-19 SUPPLEMENTAL PAID SICK LEAVE (SPSL)

To be eligible for this leave, you must be a San Joaquin County employee and be unable to work or telework due to any of the qualify reasons listed under Senate Bill 95

SECTION 1: EMPLOYEE INFORMATION	
Employee Name (Last, First)	Employee ID #
Primary Email Address	Primary Phone Number
Department's Name	
Supervisor's Name	Supervisor's Phone Number

SECTION 2: EMPLOYEE LEAVE REQUEST

☐ **I am requesting COVID-19 Supplemental Paid Sick Leave, retroactively between January 1, 2021 and March 28, 2021 for the date(s) and hour(s) listed below.** Due to the reason selected, I was unable to work (or telework) and as a result used other payable leave accruals and/or was unpaid during this period. I also certify that during this period, I was not receiving additional compensation such as wage replacement (e.g., State Disability, Unemployment, Workers' Compensation).

Requested Start Date: _____Requested End Date: _____ TOTAL HOURS: _____

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Requested Start Date: _____Requested End Date: _____ TOTAL HOURS: _____

☐ **I am requesting COVID-19 Supplemental Paid Sick Leave, between March 29, 2021 and September 30, 2021**. Due to the reason selected, I am unable to work (or telework) on date(s) and hour(s) listed below.

Type of Leave Request: ☐ Consecutive Leave ☐ Intermittent or Reduced Schedule:
Specify proposed schedule for permitted intermittent leave:
_____

Requested Start Date: _____Requested End Date: _____ TOTAL HOURS: _____

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Requested Start Date: _____Requested End Date: _____ TOTAL HOURS: _____

SECTION 3: REASON FOR LEAVE

1. ☐ I am/was subject to a quarantine or isolation period related to COVID-19 as defined by an order or guidelines of the State Department of Public Health (CDPH), the federal Centers for Disease Control and Prevention (CDC), or local health officer (PHS).

2. ☐ I have/had been advised by a health care provider to self-quarantine due to concerns related to COVID- 19.
   A. Provide name of health care provider that advised you to self-quarantine:

   _____

3. ☐ I have/had an appointment to receive a vaccine for protection against contracting COVID-19.

4. ☐ I am/was experiencing symptoms related to a COVID-19 vaccine that prevents/prevented me from being able to work or telework.

5. ☐ I am/was experiencing symptoms of COVID-19 and seeking/sought a medical diagnosis.

6. ☐ I am/was caring for a family member who is/was subject to quarantine or isolation period related to COVID-19 as defined by an order or guidelines of the State Department of Public Health (CDPH), the federal Centers for Disease Control and Prevention (CDC), or local health officer (PHS).

7. ☐ I am/was caring for a child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises.
   A. Identify the school, place of care or childcare provider closed/unavailable:

   _____

   B. ☐ YES, I certify that no other suitable person is available to care for the child(ren) during the requested leave?

   C. ☐ YES, I have attached the supporting documentation to support this request.

SECTION 4: I UNDERSTAND

1. The County must approve my request, and I may be required to meet eligibility requirements and/or submit certification or supporting documentation to be eligible for 2021 COVID-19 Supplemental Paid Sick Leave (SPSL).
2. Any leave of absence may be revoked by the Director of Human Resources upon written request of the Department Head supported by evidence that the reason for granting leave was misrepresented or has ceased to exist.
3. I am responsible to pay my share of the premiums to maintain my health benefits coverage and other deductions.
4. My share of health premiums will be paid through payroll deduction whenever I utilize leave accruals to cover the cost of premiums. If I do not have enough hours for the health deduction through payroll, I must arrange payment with the Benefits Unit.
5. I must notify my employer if I receive wage-replacement benefit (SDI, PFL, or Unemployment Benefits related to COVID -19) and understand that I will be responsible for reimbursing the County for monies paid that result in an overpayment.
6. I acknowledge that it is my responsibility to communicate with my supervisor regarding my leave status. I understand that if my circumstances change, I must immediately inform my supervisor and coordinate my return to work.

CERTIFICATION: I am unable to work or telework and hereby request/approved absence from duty as indicated and certify that such leave/absence is requested for the purpose(s) indicated. I understand that I must comply with my department's normal and customary procedures for requesting leave/approved absence (and provide additional documentation, including medical certification, if requested).
I also understand that providing false or misleading information about my absence will result in disciplinary action, up to and including termination of my employment.

_____ _____
Employee Signature Date

FOR DEPARTMENT USE ONLY

☐ Leave Request Approved

☐ Request is approved with the following modification(S): _____

☐ Request is NOT approved because: _____

☐ This employee did not provide a qualifying reason covered by **Labor Code § 248.2, SB 95.**

_____ _____
Signature-Appointing Authority or Department Representative Designee DATE

☐ A COPY OF THIS FORM MUST BE SENT TO SJCCOVID19employeeinfo@sjgov.org

FOR HUMAN RESOURCES Division USE ONLY

Date Form Received: _____ **Date Audit Completed:** _____

Human Resources Representative Completing Audit: _____