SAN JOAQUIN COUNTY
Greatness grows here.

# REQUEST FOR LEAVE OF ABSENCE
# RELATED TO 2022 COVID-19 SUPPLEMENTAL PAID SICK LEAVE (SPSL)

**Form Updated: 03/03/2022**

*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 114.*

## SECTION 1: EMPLOYEE INFORMATION

| Employee Name (Last, First) | Employee ID # | Status (FT/PT): |
|---|---|---|
| Primary Email Address | Primary Phone Number | |
| Department's Name | | |
| Supervisor's Name | Supervisor's Phone Number | |

## SECTION 2: EMPLOYEE LEAVE REQUEST

***All retro request for use of SPSL between January 1, 2022 and February 19, 2022 must be submitted before April 11, 2022.**

☐ **I am requesting COVID-19 Supplemental Paid Sick Leave, retroactively between January 1, 2022 and February 19, 2022 for the date(s) and hour(s) listed below.** Due to the reason selected on Page 2, 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: _____

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

☐ **I am requesting COVID-19 Supplemental Paid Sick Leave, between February 20, 2022 and September 30, 2022**. Due to the reason selected on Page 2, I am unable to work (or telework) on date(s) and hour(s) listed below.

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

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

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

Type of Leave Request (check one):

☐ Consecutive Leave

☐ Intermittent or Reduced Schedule:

Note: No intermittent leave for quarantine/isolation or symptoms unless approved for telework.
Please provide details of requested intermittent or reduced leave schedule:

_____

**SECTION 3: REASON FOR LEAVE - UP TO THE 40 HOURS (Pro-rated for Part Time Employees)**

1. ☐ **Vaccine-Related:**

I am attending an appointment for ☐ myself or ☐ a qualified family member to receive a ☐ vaccine or ☐ booster

☐ I am or ☐ a qualified family member is experiencing symptoms related to a COVID-19 vaccine or booster that prevents me from being able to work or telework.

A. Date of Appointment: _____

B. Provide name and relationship of family member(s): _____

***Requests for longer than 24 hours or 3 days will require documentation from a health care provider**

2. ☐ **Caring for Yourself:**

I am subject to a quarantine or isolation period related to COVID-19 as defined by an order or guidance from the California Department of Public Health, the federal Center for Disease Control and Prevention, or a local public health officer with jurisdiction over the workplace; or have been advised by a healthcare provider to quarantine; or am experiencing symptoms **and** seeking a medical diagnosis.

A. Provide name of agency or health care provider that advised you to isolate or self-quarantine:

_____

3. ☐ **Caring for a Family Member:**

I am caring for a family member who is subject to a COVID-19 quarantine or isolation period or has been advised by a healthcare provider to quarantine due to COVID-19. NOTE: The quarantine or isolation period related to COVID-19 is the period defined by an order or guidance of the California Department of Public Health, the federal Centers for Disease Control and Prevention, or a local public health officer with jurisdiction over the workplace.

A. Provide name and relationship of family member(s):_____

4. ☐ **Childcare:**

I am caring for a child whose school or place of care is closed or unavailable due 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 my child(ren) during the period of time I am requesting leave.

C. ☐ YES, I have attached current verification to support this request.

*** Current verification is required at the time of submission to approve the request.**

**SECTION 4: REASON FOR LEAVE - REQUEST FOR AN ADDITIONAL 40 HOURS (Pro-rated for Part Time Employees)**

5. ☐ I am requesting to use available SPSL hours from the "second leave bank" **(PAY CODE LSB)** and understand that I must provide proof of a positive COVID-19 test result or a health care provider certification confirming the diagnosis for myself or a qualifying family member.

☐ I have tested positive. ☐ I am caring for a family member who has tested positive.

***Proof of employee or family member's positive test must be verified following department's internal process.**

**SECTION 5: 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 2022 COVID-19 Supplemental Paid Sick Leave (SPSL).
2. All leave is subject to the maximums set forth by SB 114 of $511/day and $5,110 overall.
3. 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.
4. I am responsible to pay my share of the premiums to maintain my health benefits coverage and other deductions.
5. 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.
6. I understand I must notify my employer if I receive wage-replacement benefit (SDI, PFL, or Unemployment Benefits related to COVID -19) and will be responsible for reimbursing the County for monies paid that result in an overpayment.
7. 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 departments 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 § 248.6 & 248.7, SB 114.**

_____ _____

Signature-Appointing Authority or Department Representative Designee Date

☐ Submit completed and signed form to your agency/department Personnel Unit for processing and submittal to County Human Resources.

**FOR HUMAN RESOURCES DIVISION USE ONLY**

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

**Human Resources Representative Completing Audit: _____**