REQUEST FORM FOR RETROACTIVE SUPPLEMENTAL PAID SICK LEAVE

Please complete and return the following form to Human Resources if you are requesting COVID-19 Supplemental Paid Sick Leave ("SPSL") retroactively for leave taken on or after January 1, 2021 and prior to April 6, 2021**.** This leave may also be requested orally, in which case Human Resources will complete this form on your behalf.

Employee Name: _____

Date of Request: _____

I am requesting retroactive payments for SPSL because I was previously unable to work or telework for the following reason(s) on or after January 1, 2021 and prior to April 6, 2021:

☐ I 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 a local health officer who has jurisdiction over the workplace. The government agency that issued the quarantine or isolation order was: _____ (e.g., state, county, city).

I am requesting payment for COVID-19 Supplemental Paid Sick Leave that I took for this qualifying reason beginning on _____, 2021 and ending on _____, 2021.

☐ I was advised by a health care provider to self-quarantine due to concerns related to COVID-19. The name of the health care provider who advised me to self-quarantine due to concerns related to COVID-19 is: _____.

I am requesting payment for COVID-19 Supplemental Paid Sick Leave that I took for this qualifying reason beginning on

_____, 2021 and ending on
_____, 2021.

☐ I was experiencing symptoms of COVID-19 and was seeking a medical diagnosis.

I am requesting payment for SPSL that I took for this qualifying reason beginning on _____, 2021 and ending on _____, 2021.

☐ I was caring for a Family Member who was subject to a quarantine or isolation order or guidelines described above, or who was advised to self-quarantine by a health care provider. The Family Member I was caring for is: _____ (state the relation to you of the Family Member you were caring for).

I am requesting payment for SPSL that I took for this qualifying reason beginning on _____, 2021 and ending on _____, 2021.

☐ I was caring for a Child whose school or place of care was closed *or* otherwise unavailable for reasons related to COVID-19 on the premises. The name of the school or place of care that was closed or otherwise unavailable is:

_____.

I am requesting payment for SPSL that I took for this qualifying reason beginning on _____, 2021 and ending on _____, 2021.

☐ I was attending an appointment to receive a vaccine for protection against contracting COVID-19. My vaccination appointment was on: _____ (date) at _____ (time).

☐ I was experiencing symptoms related to a COVID-19 vaccine that prevented me from being able to work or telework. I experienced these symptoms on _____ (date(s)).

I am requesting payment for SPSL that I took for this qualifying reason beginning on _____, 2021 and ending on _____, 2021.

The dates listed above must lie between January 1, 2021 and April 6, 2021. If the dates you are requesting SPSL is after April 6, 2021 please fill out the "Employee Request for Supplemental Paid Sick Leave" accessible on the COVID-19 Information Page of the City's website.

Employee Signature/Acknowledgement:
By submitting this request for Supplemental Paid Sick Leave, I certify that: all information provided in this request is true and accurate and that I am eligible for paid leave for the reasons stated.

_____ _____

Employee Signature Date

_____ _____

Human Resources Signature Date