City of Delano

Employee Request Form for Prospective COVID-19 Supplemental Paid Sick Leave ("SPSL")

Employee Name: _____ **Date of Request: _____**

Department: _____ **Position Title: _____**

Please complete and return the following form to Human Resources if you are requesting COVID-19 Supplemental Paid Sick Leave ("SPSL").

For the purposes covered by this form, the term "Family Member" means the employee's child, parent, spouse, registered domestic partner, grandparent, grandchild, or sibling. See Labor Code section 245.5, subsection (c) for additional information.

Qualifying Reasons 1-7:

I understand that I am entitled to a certain amount of SPSL for Qualifying Reasons 1-7 (as enumerated below) between January 1 and September 30, 2022. I am requesting SPSL for one of these reasons because I am unable to work or telework for that reason. I understand the City will deduct from my SPSL entitlement an amount of SPSL equal to my usage of such leave.

I am requesting SPSL for the following reason:

1._____ I am 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 has issued the quarantine or isolation order is:

_____

(e.g., state, county, city)

2._____ I have been advised by a health care provider to isolate or quarantine due to COVID-19. The name of the health care provider who has advised me to isolate or quarantine due to COVID-19 is: _____

3._____ I am attending an appointment either for myself or a Family Member to receive a vaccine or a vaccine booster for protection against COVID-19. The vaccination appointment is on: _____ (date) at _____ (time)

The Family Member getting vaccinated is: _____

4._____ Either I am or a Family Member is experiencing symptoms related to a COVID-19 vaccine or a vaccine booster.

_____ I understand that for each vaccination or vaccine booster, the City limits the total SPSL that I may use up to 3 days unless I provide verification from a health care provider that I am or my Family Member is continuing to experience symptoms related to the COVID-19 vaccine or vaccine booster.

The Family Member experiencing symptoms is: _____

5._____ I am experiencing symptoms related to COVID-19 and am seeking a medical diagnosis.

6._____ I am caring for a Family Member who is either (1) subject to a CDPH, CDC, or local health officer order or guidance to isolate or quarantine, or (2) who has been advised to isolate or quarantine by a health care provider.

The Family Member I am caring for is: _____
(state the relation of the Family Member for whom you are providing care)

The government agency that has issued the quarantine or isolation order is: _____
(e.g., state, county, city)

The name of the health care provider who advised my Family Member to isolate or quarantine due to COVID-19 is: _____

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

The name of the school or place of care that is closed or otherwise unavailable is: _____

Qualifying Reasons 8:

I understand that I am entitled to a certain amount of SPSL for Qualifying Reason 8 (as enumerated below) between January 1 and September 30, 2022. I am requesting SPSL for this reason because I am unable to work or telework for that reason. I understand the City will deduct from my SPSL entitlement an amount of SPSL equal to my usage of such leave.

I am requesting SPSL for the following reason:

8._____ I tested positive for COVID-19, or a Family Member for whom I provide care for tested positive for COVID-19.

The Family Member I provide care for is: _____

AND

_____ I agree to provide the City documentation of the positive test result from an independent third-party test provider (i.e., the City will not accept self-administered and self-read test results). Further, I understand that the City is not obligated to pay me for this SPSL usage if I fail to provide documentation of the positive test result as provided here.

I am requesting SPSL beginning on _____, 2022.

I expect to use SPSL until _____, 2022.

_____ _____

Employee Signature Date

For Human Resources Use Only:

_____

Signature of Human Resources Personnel

Date Request Received by Human Resources: _____