

## Request for COVID-19 Supplemental Paid Sick Leave

Employee Name: \_\_\_\_\_ Department: \_\_\_\_\_

Personal email address: \_\_\_\_\_ Cell phone number: \_\_\_\_\_

### I am requesting leave for the following reason (check all that apply):

- ☐ I am subject to State, CDC or local quarantine or isolation related to COVID-19\*
- ☐ I am subject to quarantine per health care provider guidance related to COVID-19\*
- ☐ I am experiencing symptoms of COVID-19 and seeking a medical diagnosis\*
- ☐ I am attending an appointment for a COVID-19 vaccine
- ☐ I am experiencing symptoms of a COVID-19 vaccine that prohibits me from working or telecommuting
- ☐ I am caring for a family member who is subject to a State, CDC or local quarantine or isolation related to COVID-19 per health care provider guidance\*
- ☐ I am caring for a child due to school/childcare closure, or place of care being unavailable, due to COVID-19
- Facility/District Name: \_\_\_\_\_ Date of Closure: \_\_\_\_\_
- Please list name(s) of child(ren): \_\_\_\_\_

\* Medical certification may be required. If required, medical certification must include employee's name, dates for which leave is requested, the coronavirus-qualifying reason for leave, a statement that the employee cannot work/telecommute because of this reason, and the name of the medical provider.

### Method of Leave Requested (check one)

- ☐ Consecutive Leave ☐ Intermittent or Reduced Schedule (Attach schedule on a separate page)

### Pay While on Leave

- ☐ I will be utilizing Supplemental Paid Sick Leave

Date leave is to begin: \_\_\_\_\_ Anticipated return date: \_\_\_\_\_

Additional Information: \_\_\_\_\_

Date: \_\_\_\_\_ Employee's Signature: \_\_\_\_\_

*I attest that this leave request, to the best of my knowledge and understanding, is true, correct, and complete. I understand the City of Carlsbad reserves the right to request supporting documentation (i.e. medical certification), as needed and I am required to provide requested supporting documentation within the specified time frame for the requested benefit.*

<b>HR USE ONLY</b>	<input type="checkbox"/> Request approved and designated as Supplemental Paid Sick Leave
	Approved hours: _____
	<input type="checkbox"/> Request for leave does not meet the requirements for the following reasons: _____
HR Signature: _____ Date: _____	