

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 a quarantine or isolation period related to COVID-19
- I was advised by a healthcare provider to quarantine or isolate due to COVID-19
- I am attending an appointment for myself or a family member to receive a COVID-19 vaccine or vaccine booster
- I am experiencing symptoms, or caring for a family member experiencing symptoms, related to a COVID-19 vaccine or booster
- I am experiencing COVID-19 symptoms and seeking a medical diagnosis
- I am caring for a family member who is subject to quarantine or isolation or has been advised by a healthcare provider to quarantine or isolate due to COVID-19
- I am caring for a child whose school or place of care is closed or unavailable due to COVID-19 on the premises

I am requesting leave for a positive COVID-19 test (check the applicable box below and complete the certification):

- I tested positive for COVID-19
- A family member that I am caring for tested positive for COVID-19

I, _____, am requesting leave due to a positive test result for myself or a family member that I am caring for. I attest that a COVID-19 test was administered on _____ and the result of that test was positive. The type of COVID-19 test administered was _____.

Date leave is to begin: _____

Date returned to work: _____

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 (medical certification or positive test results), as needed and I am required to provide requested supporting documentation within the specified time frame for the requested benefit.