**Paid COVID-19 Leave Request Form**

To request paid sick leave for absences related to the coronavirus, please complete the following request form and submit to your manager or the human resources department either prior to leave or as soon as possible after leave commences. Verbal notice will be accepted until a form can be completed.

Documentation supporting the need for leave must be included with this request.

Employee name (print clearly): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested leave start date: \_\_\_\_\_\_\_\_ End date: \_\_\_\_\_\_\_\_

Number of hours of paid sick leave requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A combined maximum of 10 days (80 hours) of coronavirus-related paid sick leave is available from all employers an individual works for. I attest that:

❏ I have NOT taken coronavirus-related paid sick leave after March 31, 2021, while working for another employer.

❏ I have taken \_\_\_\_ hours of coronavirus-related paid sick leave after March 31, 2021, while working for another employer.

❏ I wish to take intermittent leave during the following days and hours:

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |

I am requesting this paid sick leave due to my inability to work (or telework) because (check the appropriate reason below):

1. I am subject to a federal, state or local quarantine or isolation order related to COVID–19.

2. I have been advised by a health care provider to self-quarantine due to concerns related to COVID–19.

3. I am experiencing symptoms of COVID–19 and seeking a medical diagnosis.

4. I am obtaining a COVID-19 vaccination.

5. I am recovering from an illness related to receiving a COVID-19 vaccination.

6. I am seeking or waiting for test results or a medical diagnosis for COVID-19, including results or diagnosis requested by the employer.

7. I am experiencing another substantially similar condition specified by the secretary of health and human services.

- I am accompanying a qualifying individual to obtain immunization related to COVID-19.

- I am caring for a qualifying individual who is recovering from any injury, disability, illness, or condition related to the immunization.

8. I am caring for an individual who is subject to either number 1 or 2 above.

9. I am caring for my child whose primary or secondary school or place of care has been closed, or the child care provider is unavailable due to COVID–19 precautions; and,

- No other suitable person is available to care for my child during the requested period of leave.

- Special circumstances exist requiring the need for leave to care for my child ages 15-17.

I have attached appropriate documentation supporting my need for leave.

Employee signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Manager signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HR Manager signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employee Statement Supporting Leave**

I, , provide the following information in support of my request for coronavirus-related paid sick leave (complete all that apply):

**Leave due to a government-issued quarantine or isolation order.**

Name of the issuing government agency for the quarantine or isolation order:

Effective dates of the order: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Leave due to a health care provider's advice to self-quarantine.**

Name of the health care provider advising me or the individual I am caring for to

self-quarantine:

Written documentation is available and attached: ❏Yes ❏No

Name and relation of the individual who I am needed to care for:

Name: Relation:

**Leave due to a school or place of child care closed due to COVID-19.**

Name of school or place of care:

Name of child care provider unavailable due to concerns related to COVID-19:

Name and age of child or children I am needed to care for:

Name: Age:

Name: Age:

Name: Age:

No other suitable person is available to care for my child for the requested leave period due to:

The special circumstances requiring my need for leave to care for a child age 15-17 are:

**Leave due to obtaining a COVID-19 vaccination.**

Date(s) COVID-19 vaccination received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Written documentation is available and attached: ❏Yes ❏No

**Leave due to recovering from an illness related to receiving a COVID-19 vaccination.**

Date(s) COVID-19 vaccination received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date(s) of COVID-19 vaccination-related illness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Leave due to seeking or waiting for test results or a medical diagnosis for COVID-19, including results or diagnosis requested by the employer.**

Name of the health care provider providing the test results or diagnosis:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Written documentation is available and attached: ❏Yes ❏No

**Leave due to a substantially similar condition specified by the secretary of health and human services.**

Provide details regarding the need for this leave:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I attest that the above information is accurate and complete. I understand falsification of any information given may lead to disciplinary action.

Employee signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_