REQUEST FOR DISTRICT PAID COVID-19 SUPPLEMENTAL PAID SICK LEAVE
10/1/21 THROUGH 12/31/21 ONLY

Employee Name				
Department/Site				SS# xxx-xx-
Requested Leave Dates	Start Date *(First day on leave)*		End Date *(Last day on leave)*	

EMPLOYEE MAY REQUEST REIMBURSEMENT if the employee was unable to work from 10/1/21 through 12/31/21 for any of the following Covid-19 related reasons:

☐ **EMPLOYEE:** The employee was subject to a quarantine or isolation period related to COVID-19 as defined by an order or guidance of the State Department of Public Health, the federal Centers for Disease Control and Prevention (CDC), or a local public health officer with jurisdiction over the workplace; the employee was experiencing COVID-19 symptoms and sought medical diagnosis and was advised by a health care provider to isolate or quarantine due to COVID-19.

☐ **SCHOOL/CHILDCARE:** The covered employee was caring for a child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 **on the premises**.

☐ **FAMILY MEMBER:** The employee was caring for a family member who was subject to a COVID-19 quarantine or isolation period as defined by the State Department of Public Health, the CDC or local public health officer or who was experiencing COVID-19 symptoms and was advised by a healthcare provider to quarantine due to COVID-19.

☐ **VACCINE:** The employee received the COVID-19 vaccine or could not work due to vaccine related symptoms.

Any previous use of Supplemental Paid Sick Leave (SPSL) provided for by the State or the District from 1/1/21 – 9/30/21 will be deducted from the employee's available allotment of leave. Reimbursement not to exceed:

- Full time employees: Not to exceed 80 hours/10 days
- Part-Time Employees: Prorated based on the number of hours the employee is normally scheduled to work/not to exceed 10 days.
- Employees paid at their regular rate of pay, not to exceed the maximum rate of $511/day, $5,110 in total.

DEADLINE TO APPLY FOR REIMBURSEMENT IS 4/1/22.
NO LATE SUBMISSIONS WILL BE ACCEPTED AFTER THIS DATE.

☐ **I HAVE READ AND UNDERSTAND THE REQUIREMENTS FOR REIMBURSEMENT FOR COVID-19 SUPPLEMENTAL PAID SICK LEAVE FROM 10/1/21 – 12/31/21.**

Certificated and/or Management Employees whose daily rate of pay exceeds the SPSL maximum rate.

If your daily rate of pay exceeds the daily SPSL cap of $511 per day, you may request to supplement the balance of each day with your available paid leave. Please check the appropriate box if you wish to supplement your pay: ☐ **Sick leave** ☐ **Vacation**
If no box is checked, you will be paid at the maximum Supplemental Paid Sick Leave (SPSL) cap.

By signing below, I hereby acknowledge that I was unable to work because of the COVID-19 reason checked above and I have read and understand the requirements to take leave.

_____ _____
Employee Signature *Date*

PEOPLE SERVICES USE ONLY Date Received: _____ Employee EIN #_____

COVID Log/Questionnaire/Notification Date_____ Positive COVID Test Result Received: _____ Eligible # days: _____