COVID-19 SUPPLEMENTAL PAID SICK LEAVE REQUEST FORM
Eligible Dates: January 1, 2022 – December 31, 2022

Employee Information

Name:	Department:	Employee #:
Contact Phone #:	Personal email:	

COMPLETE ONE FORM (WITH SUPPORTING DOCUMENTATION) FOR EACH QUALIFYING REASON. REFER TO THE COVID-19 LEAVE GUIDE FOR SUBMITTAL INSTRUCTIONS.

FIRST BANK- SPSL/General, Qualifying Reasons

I am requesting **up to 40 SPSL/General hours** due to one of the following qualifying reasons (PLEASE CHECK ONE):

☐ 1. I was subject to a quarantine or isolation period related to COVID-19, as defined by a CDC/CDPH/local Health Order or guidelines.

☐ 2. I was advised by a Health Care professional to self-quarantine due to concerns related to COVID-19.

☐ 3. I attended or will attend an appointment to receive a COVID-19 vaccine or booster for a family member or myself. Relationship to Individual: ________________________ (e.g. child, parent, spouse/registered domestic partner, grandparent, grandchild or sibling)

☐ 4. I experienced symptoms or cared for a family member experiencing symptoms related to a COVID-19 vaccine or booster that prevented me from being able to work.

☐ 5. I am experienced symptoms related to COVID-19 and sought a diagnosis.

☐ 6. I cared for a family member who is subject to quarantine or isolation period related to COVID-19. Relationship to individual: ____ (e.g. child, parent, spouse/registered domestic partner, grandparent, grandchild or sibling).

☐ 7. I cared for a child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises. ***Regularly scheduled school breaks or holidays do not count as school closures).*** Please include child's school schedule or justification for time off:

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Beginning leave date:	End leave date:	Return to Work Date:

Indicate total number of hours requested for the checked qualifying reason___________

SECOND BANK- SPSL/Positive, Qualifying Reasons

I am requesting **up to 40 SPSL/Positive hours** due to one of the following (PLEASE CHECK ONE):

☐ 8. ☐ I tested positive for COVID -19 ☐ I cared for a family member who tested positive for COVID-19

Beginning leave date:	End leave date:	Return to Work Date:

Indicate total number of hours requested for the checked qualifying reason ___________

Did you received State Disability Insurance (SDI), Worker's Compensation (WC) benefits, or any other Disability Insurance benefits during the dates and times/hours you are claiming to be retroactive due to above-checked qualifying reason(s)? ☐Yes ☐ No

I certify under penalty of perjury the foregoing is true and correct. I further understand that my department will require supporting documentation before granting Supplemental Paid Sick Leave benefits.

Employee signature: ____ Date: _______________

RETRO REQUESTS ONLY - DEPARTMENT USE / TO BE COMPLETED BY DEPARMENTS PAYROLL ADMINISTRATOR /SUPERVISOR AND SUBMITTED TO AUDITORS OFFICE WITHIN 30 DAYS FROM THE FIRST DAY OF LEAVE

ORG KEY:

Date	Adjustment FROM Paycode (-)	Adjustment TO Paycode (+)	Hours

***For additional days, please attach*

*Please use payroll code **SPSL Regular/General** or SPSL **Extra Help/General** for reasons 1-7 use **SPLS Regular/Positive** or **SPSL Extra Help/Positive** for reason 8*

Department Review: ☐ Approved ☐ Denied Timekeeper's Signature:__________________________ Date: _____________

Department Head Signature:________________________ Date: ____________