CA COVID-19 Supplemental Paid Sick Leave (CA SPSL 2022) Request Form

Employee Name	Employee ID Number	Date
Job Title	Supervisor	Department
Leave Start Date	Leave End Date	Total Hours Requested

I CERTIFY THAT I AM UNABLE TO WORK (OR TELEWORK) FOR THE FOLLOWING REASON:

☐ I am subject to a **federal, state, or local quarantine or isolation** order related to COVID-19 that specifically prevents me from working.
Name of the government entity issuing the order:

☐ I have been **advised by a health care provider to isolate or quarantine** due to COVID-19.
Name of the advising healthcare provider:

☐ I have **symptoms of COVID-19** and I am seeking a diagnosis; I am seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of COVID-19.

☐ I am **caring for a family member** who is subject to a federal, state, or local quarantine or isolation order related to COVID-19, or has been advised by a health care provider quarantine or isolate due to COVID-19.
Name of person I am caring for and our relationship:

Name of the government entity issuing the order:

OR

Name of the advising healthcare provider:

☐ I **need to care for my child(ren)** because their school or childcare provider is closed or unavailable because of COVID-19. **I certify that no other suitable person is available to care for the child(ren) during the period of requested leave.**
Name(s) and age(s) of child(ren):

Name of closed school(s) or place(s) of care:

☐ I **need to attend a COVID-19 vaccine or vaccine booster appointment for myself or my family member, or have a vaccine related symptoms or are caring for a family member with vaccine-related symptoms.** I understand that for each vaccination or booster appointment and consequent side effects for myself or my family member, I have 24 hours of leave unless a health care provider verifies that more recovery time is needed then I will need to provide a note from my or my family member's healthcare provider.

☐ I have **tested positive for COVID-19 or am caring for a family member who tested positive for COVID-19**.

I certify that the above information is truthful and understand that misrepresenting my need for leave is grounds for discipline, up to and including termination.

Employee Signature: ____

If signing electronically, please type your full name, followed by "e-signed."

Created 2022