SANTA BARBARA CITY COLLEGE
Human Resources

COVID Supplemental Paid Sick Leave

(Effective 3/29/21 through 9/30/21)

Employee Name:_____ Date of Request:_____

Job Title:_____Employee K# :_____

Department:_____ Supervisor Name:_____

I am unable to work or telework and request to use COVID-19 Paid Sick leave for one of the following reasons:

1. ☐ I am subject to a Federal, State of local quarantine or isolation order related to COVID-19;
2. ☐ I have been advised by a health care provider to self-quarantine related to COVID-19;
3. ☐ I am experiencing COVID-19 symptoms and am seeking a medical diagnosis;
4. ☐ I am caring for an individual subject to an order described in (1) or self-quarantine as described in #2;
5. ☐ I am caring for my child whose school or place of care (or child care provider is unavailable) due to COVID-19 related reasons; or
6. ☐ I am experiencing any other substantially similar condition specified by the US Department of Health and Human Services.
7. I need time off to receive COVID vaccination
8. ☐ Consecutive Leave (Specify dates with an attachment).

   ☐ Intermittent Leave Schedule (Specify schedule with an attachment indicating the hours/days you plan on working and the hours/days you plan on taking as COVID-19 paid sick leave).

Paid leave entitlement :

Up to two weeks (80 hours, or a part-time employee's equivalent) of paid sick leave based on higher of their regular rate of pay, or the applicable state or Federal minimum wage.

_____ _____
Employee Signature Date

_____ _____
Human Resources Review & Signature Date
Cc: Payroll