



COVID-19 Paid Sick Leave

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 or 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 symptoms related to COVID-19 vaccine that prevent me from working or teleworking
7. ☐ I am attending an appointment to receive a vaccine that for protection against contracting COVID-19 symptoms related to COVID-19.

☐ 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 under Board Resolution

Employee Signature

Date

Human Resources Review & Signature
Cc: Payroll

Date