SANTA BARBARA CITY COLLEGE

Human Resources

COVID-19 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 meet one of the reasons listed below:

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 a family member who is 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.
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 for protection against contracting 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).

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