SUBMIT TO BENEFITS

EMPLOYEE CERTIFICATION OF NEED FOR SUPPLEMENTAL PAID SICK LEAVE

(SB 114) (*Effective January 1, 2022 through September 30, 2022)*

Employee Name: ___________________________ Job Title: _________________ ______ Full-time ___ Part-time

I request SPSL from: ______________________ to ________________________ for a total of _______ hours.
(beginning date) **(ending date)**

(Not to exceed 40 hours for full-time employees for caring for themselves or others, or up to an additional 40 hours if employee or family member tests positive for COVID-19; prorated for part time employees)

I certify that I was unable to work (or telework) because: (check all that apply)

___ Employee was subject to a quarantine or isolation period related to COVID-19 as defined by an order/guidance of CDPH, Centers for Disease Control and Prevention, local public health officer, or healthcare provider who has jurisdiction over the workplace or employee to isolate or quarantine due to COVID-19.

Name of Agency/Clinic/Medical Provider Providing Direction (or document): ____

Contact Information: ____________________________ Date Advice Was Given: _____________________________________

___ Employee was caring for a family member* who: (1) is subject to a CDPH, CDC, or local health officer order or guidance to isolate or quarantine, OR; (2) has been advised by a health care provider to isolate or quarantine.

Name of Medical Provider: ___________________ Date Advice Was Given: ____

Contact Information: ____

- *If employee is requesting more than 5 days due to family member being COVID positive, please provide documentation that you tested on day 6 and still were positive.*

___ Employee was attending an appointment for themselves or a family member* to receive a vaccine or a vaccine booster for protection against COVID-19. (Proof of vaccination appointment required.).

Name of Agency/Clinic/Medical Provider: ____

Date/Time of Appointment: _____________________ Location: ____

___ Employee is experiencing symptoms, or caring for a family member* experiencing symptoms, related to a COVID-19 vaccine/booster that prevent the employee from being able to work or telework. (Proof of vaccination appointment required; Doctor's note required if the appointment plus symptoms exceed 3 days.)

Name of Agency/Medical Provider: ____

Date: _________________ Location: ____

___ Employee was experiencing COVID symptoms & seeking medical diagnosis. (Doctor's note needed for 3 or more days)

Name of Medical Provider: ___________________________ Date Seen: ____

Contact Information: ____

___ Employee was caring for a child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises. (Note from school or childcare facility required.)

Name of School Or Child Care Provider: ____

School Contact Information: ____

Date School/Care Became Unavailable: ____

** Per SB 114, a "family member" is a: **child, parent, spouse, registered domestic partner, grandparent, grandchild, or sibling**.*

I certify that I am/was unable to work in person or remotely for the reason(s) above. If the District need more documentation (such as from doctor, School/Child Care to support request) in the future to support our ability to use state/federal funds for leaves, I agree to assist in their requests to the best of my abilities, consistent with HIPPA protections.

Employee Name: _______________________ Signature: ______________________________ Date: __________