Telephone (956) 969-6530
Fax (956) 973-2500

Weslaco Independent School District
Risk Management Department

319 West 4th Street
P.O. Box 266
Weslaco, TX 78599-0266

LEAVE REQUEST FORM—LOCAL COVID-19-RELATED LEAVE

Name	**Employee ID**
Department/campus	**Position**
Email	**Phone number**
Date	**Duration of leave** *(specify dates requested)*

The district provides local COVID Extended leave for COVID-19-related absences. An employee requesting local COVID-19 leave must complete this form and return it to the Risk Management Department as soon as the need for leave is identified. Documentation supporting the need for leave should be included when the request is submitted.

COVID-19-related local leave is paid leave to contract and non-contract employees ("COVID Extended Leave") when 1) the employee is test-confirmed to have COVID-19 and has been instructed not to report to work as a result of the confirmed test; or 2) required to quarantine due to a directive from the District, a licensed physician, or a local health authority because of known close contact with an individual who is lab confirmed to have COVID-19. As per CDC guidelines, individuals who are fully vaccinated are not considered in known close contact.

In order for the employee's leave to be eligible, the employee must provide proof of a positive COVID-19 test for the employee within three (3) days of advising the District of the need for leave. Without proof of testing positive for COVID-19, employee's leave will be taken from their state or local leave pursuant to Board Policy.

COVID extended leave is capped at ten (10) days and may be claimed retroactively to June 1, 2021.

I request COVID -19 related local leave for the following reason(s):

☐ I have tested positive for COVID-19 and have been instructed not to report to work as a result of the confirmed test;

☐ I am required to quarantine due to a directive from the District, a licensed physician, or a local health authority because of known close contact with an individual who is lab confirmed to have COVID-19.Name of health care provider requiring self-quarantine: _____

☐ I was subject to quarantine due to a positive COVID-19 test, or was in known close contact with an indivudial who was lab confirmed to have COVID-19 on or after June 1, 2021 and was not fully vaccinated.

☐ The employee qualifies for leave.

☐ The employee does not qualify for leave.

For office use only:

Date of Employment _____

Medical certification provided ☐ Yes ☐ No

Approved by:_____
Name and title

Date:_____