2023 COVID-19 SUPPLEMENTAL PAID SICK LEAVE

Please return this form to Angelica Escalante in Human Resources at aescalante@hlpusd.k12.ca.us

A leave request based on an employee who is unable to work or telework due to employee who (1) is subject to Federal, State, or local quarantine or isolation order; (2) has been advised by a healthcare provider to self-quarantine; (3) is attending an appointment to receive a vaccine or booster or family member is attending an appointment to receive a vaccine or a booster (4) is experiencing symptoms related to a COVID-19 vaccine (5) is experiencing symptoms of the COVID-19 and seeking medical diagnosis; (6) is caring for individual subject to an order as described in (1) or has been advised as in (2) or is ill as in (4) or (5); (7) is caring for a child at home due to school or place of care closure for reasons related to COVID-19 on the premises. ***The availability of this leave if from January 1, 2023 and will expire June 30, 2023.***

DATE OF REQUEST

PRINT OR TYPE NAME OF REQUESTOR (LAST, FIRST AND MIDDLE)

EMPLOYEE I.D. NUMBER

HOME TELEPHONE NUMBER ( )

NAME OF DIVISION

WORK LOCATION

JOB TITLE

NAME OF IMMEDIATE SUPERVISOR

REQUESTED DATES OF LEAVE

FROM: **THROUGH:**

CONTINUOUS

INTERMITTENT

No of Days per Week ____

(Up to 5 work days or 40 hours for full time employees with proof of a negative lab COVID-19 test result)

(Up to 5 additional work days or 40 hours for full time employees with proof of a positive lab COVID-19 test result for a maximum of 10 work days or 80 hours for full time employees)

REASON FOR LEAVE Full Pay (up to $511 per day)

☐ (1) Employee is subject to Federal, State, or local quarantine or isolation order

☐ (2) Employee has been advised by a healthcare provider to self-quarantine

☐ (3) Employee or employee's family member is attending an appointment to receive a COVID-19 vaccine or booster

☐ (4) Employee is experiencing symptoms related to a COVID-19 vaccine or booster (up to 3 days without medical note)

☐ (5) Employee is experiencing symptoms of the COVID-19

☐ (6) Employee is caring for individual subject to an order as described in (1) or has been advised as in (2) or who is ill as in (4) or (5)

☐ (7) Employee is caring for a child at home due to school or place of care closure for reasons related to COVID-19 on the premises.

SIGNATURE OF REQUESTOR

DATE SIGNED

For Human Resource Services Use Only

☐ **Proof of COVID-19 test results of employee or employee's family member has been submitted**

☐ APPROVED ☐ DENIED

AUTHORIZED SIGNATURE

DATE SIGNED

PAY TYPE:

☐ **FULL PAY (up to $511 per day)**

☐ **Hourly** _____ **NUMBER OF HOURS PER DAY** **$**_____ **HOURLY RATE**

☐ **OTHER** _____