



COVID-19 DSW and WORK RESTRICTIONS: SELF-CERTIFICATION FORM

(Please return this completed form to a department human resources representative, supervisor or manager)

Name: _____ (Please print)	_____	_____
	(DSW ID Number)	(Contact Phone)
Address: _____ (Street)	_____	
	(City, State, Zip Code)	
Department: _____	_____	
(Department Name)	(Division/Section/Supervisor)	

I CERTIFY I AM UNAVAILABLE FOR A DSW ASSIGNMENT OR OTHER WORK IN THE WORKPLACE AND/OR IN THE FIELD FOR THE FOLLOWING REASON:

<input type="checkbox"/> Childcare Due to School/Childcare Closure
Child(ren)'s Name: _____ Age: ____ Name: _____ Age: ____ Name: _____ Age: ____ Name: _____ Age: ____
School/Childcare Provider: _____ City: _____
<input type="checkbox"/> My <input type="checkbox"/> My Family Member's Health Care Provider Ordered/Advised Me to Quarantine/Isolation Due to a Vulnerable Condition
Health Care Provider's Name: _____ Order/Advice Date: _____
Address: _____ City: _____ State: ____
<input type="checkbox"/> I Am Concerned About Exposure to COVID-19 <input type="checkbox"/> I Am Concerned About Exposing My Family Member(s) to COVID-19
<input type="checkbox"/> Other (Please explain): _____

AVAILABLE HOURS FOR TELECOMMUTING (If available for telecommuting, identify the days and hours you can work)

<input type="checkbox"/> Mon _____ to _____	<input type="checkbox"/> Tue _____ to _____	<input type="checkbox"/> Wed _____ to _____	<input type="checkbox"/> Thu _____ to _____
<input type="checkbox"/> Fri _____ to _____	<input type="checkbox"/> Sat _____ to _____	<input type="checkbox"/> Sun _____ to _____	

ACKNOWLEDGEMENT AND CERTIFICATION

I understand that I am a Disaster Service Worker (DSW) and generally must accept a DSW assignment. I certify that I am unable to perform this assignment on the grounds stated above. I understand that I will not remain on paid furlough if unavailable for a DSW assignment or other assigned work. I understand that if I decline work based on concerns about exposure to COVID-19, that I may use accrued leave, except sick leave. If operationally feasible, my Department may authorize me to telecommute.

If my certification is based on a medical condition, or other factors creating a higher risk for severe COVID-19 illness, I certify that my health care provider has advised me to isolate and avoid going to a worksite or in the field.

I understand that any exemption the City provides to laws requiring me to serve as a DSW during the COVID-19 public health crisis must be based on the facts stated herein. I certify the information I am providing in this self-certification form is truthful and complete. I also understand that providing false or misleading information about my ability to serve as a DSW may result in disciplinary action.

Signature: _____ **Date:** _____