City and County of San Francisco
Carol Isen
Human Resources Director

Department of Human Resources
Connecting People with Purpose
www.sfdhr.org

COVID-19 LEAVE REQUEST FORM

Name: _____ _____ _____
(Please print) (DSW ID Number) (Contact Phone)

Address: _____ _____
(Street) (City, State, ZIP)

Department: _____ _____
(Division/Section/Supervisor) (Department Name)

REASON FOR LEAVE REQUEST and ABSENCE DATES

☐ Public Health or CDC Required Quarantine or Isolation
☐ Health Care Provider Advised Quarantine or Isolation
☐ COVID-19 Symptoms and Seeking Diagnosis – Employee
☐ Care for a Family Member Quarantining or Isolating Per Above
☐ Child(ren)'s School/Childcare Closure/Unavailability Due to COVID-19
☐ COVID-19 Vaccination Appointment **OR** Vaccine Side Effects ☐ Employee ☐ Family Member
☐ Self-Isolation Due to Vulnerable Medical Condition
☐ Post-Travel Quarantine ☐ Essential Travel ☐ Nonessential

Absence Dates: From: _____ To: _____ **TOTAL HOURS**: _____

TYPE OF PAY REQUESTED DURING LEAVE

☐ **CSP –State COVID-19 Sick Leave** ☐ **COV Sick Leave**
☐ **Sick Leave** ☐ **Vacation** ☐ **Floating Holiday** ☐ **Compensatory Time**

SICK LEAVE AND VACATION ADVANCE and AGREEMENT

CITY LEAVE ADVANCE: For employees who have exhausted all of the above pay, except Paid Administrative Leave:
Due to the coronavirus I request a ☐ **Sick Leave Advance** ☐ **Vacation Advance of** _____ **Hours** (Up to 80 hours) **to cover my leave.** (Departments have discretion to determine the appropriate leave type and whether employees are eligible.)
I have read and understand the SICK LEAVE AND VACATION ADVANCE PROCEDURE. I understand that any sick leave or vacation advanced is a loan of time not yet earned that I am required to repay by applying accrued sick leave or vacation as it is earned to the outstanding balance. I understand that if I separate from the City, I will repay the remaining unpaid balance, if any.

Date:

Signature: _____ _____

Supervisor/Manager (Appointing Officer)	Signature	**For Advances Is Accrued Leave Exhausted?**		**Approve**	**Deny**
	Signature	**Yes** ☐	**No** ☐	☐	☐
Personnel Officer	**Paid Administrative Leave**				**Eligible** ☐

cc: Official Employee Personnel Folder

COVID-19 LEAVE REQUEST FORM

REQUIRED INFORMATION (*Complete Only Sections That Apply to Your Leave and Sign Acknowledgement*)

Public Health or CDC Required Quarantine or Isolation: I am subject to a COVID-19 related public health order or guideline that prevents me from going to work or teleworking.

Name of public health entity issuing order or guideline: _____

Order Date: _____ (*Employees may be required to provide a copy of the quarantine order*.)

☐ **It's not me, instead I'm taking care of a family member subject to such an order or guideline, and I cannot work or telework.**

Health Care Provider Advised Quarantine/Isolation: My health care provider has advised me to quarantine or isolate, and I cannot go to work or telework.

Health Care Provider's Name: _____

Provider's Address: _____ City: _____ State: _____

Order/Advice Date: _____ (*Employees may be required to provide a copy of the medical certification*.)

☐ **It's not me, instead I'm taking care of a family member who received this advice, and I cannot work or telework.**

Due To COVID-19 Symptoms and Seeking Diagnosis: I am experiencing COVID-19 symptoms and will receive testing or other diagnostic services.

Provider/Clinic/Test Site Name: _____

Address: _____ City: _____ State: _____

Test/Exam Date: _____

School or Childcare Provider Closure/Unavailability Due to COVID-19: I need to care for my child(ren), and I cannot work or telework because my child(ren)'s school has closed, childcare place has closed or childcare provider is unavailable due to a COVID-19, and no other suitable person is available to care for my child(ren) during the time I need to take leave. Name(s) and age(s) of child(ren) I need to care for:

1. _____ Age: _____ 2. _____ Age: _____
3. _____ Age: _____ 4. _____ Age: _____

Name(s) of school/childcare place/provider: _____

_____

☐ **There are special circumstances requiring my leave to care for my child(ren) age(s) 15-17, or adult child age 18, or older.**

☐ **LEAVE TO SELF-QUARANTINE DUE TO A COVID-19 CLOSE CONTACT, ILLNESS FROM VACCINE SIDE EFFECTS, OR TRAVEL OUTSIDE THE SAN FRANCISCO BAY REGION:** I cannot work or telecommute for one of these reasons.

☐ **MY HEALTH CARE PROVIDER RECOMMENDED OR ADVISED ME TO ISOLATE**, or told someone in my household that I should isolate for their safety, because of vulnerability, but I can telecommute or may be able to return to work with accommodations.

Health Care Provider's Name: _____
Address: _____ City: _____ State: _____
Advice Date: _____

ACKNOWLEDGEMENT

I CERTIFY THAT MY ABSENCE REQUEST IS FOR THE COVID-19 RELATED REASON STATED ON THIS SICK LEAVE, EMERGENCY FMLA or VACATION REQUEST FORM (COVID-19).

I UNDERSTAND THAT LEAVE AND PAY APPROVED BECAUSE OF THE COVID-19 PUBLIC HEALTH CRISIS IS SUBJECT TO PROVISIONS IN CIVIL SERVICE RULES, THE MAYOR'S PROCLAMATIONS, AND RELATED RULES PROVIDING LEAVE BENEFITS. I ALSO UNDERSTAND THAT PROVIDING FALSE OR MISLEADING INFORMATION ABOUT MY ABSENCE MAY RESULT IN DISCIPLINARY ACTION.

Signature: _____ **Date:** _____