City and County of San Francisco
Carol Isen
Human Resources Director

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

PUBLIC HEALTH EMERGENCY LEAVE REQUEST FORM

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

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

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

REASON FOR LEAVE REQUEST - EMPLOYEE

☐ Federal, State, or Local Quarantine or Isolation Order/Recommendation/Requirement
☐ Health Care Provider Quarantine or Isolation Order/Advice
☐ Symptoms and Seeking Diagnosis or Receipt of a Positive Medical Diagnosis for an Infectious, Contagious, or Communicable Disease
☐ Air Quality Emergency – Employees in the "Vulnerable Population" Who Primarily Work Outdoors Only (May Require Health Care Provider Certification)

REASON FOR LEAVE REQUEST – FAMILY MEMBER

☐ Care for a Family Member Subject to Federal, State, or Local Quarantine or Isolation Order/Recommendation/Requirement
☐ Care for a Family Member Subject to Health Care Provider Quarantine or Isolation Order/Advice
☐ Care for a Family Member with Symptoms and Seeking Diagnosis or Receipt of a Positive Medical Diagnosis for an Infectious, Contagious, or Communicable Disease
☐ Child(ren)'s School/Childcare Closure/Unavailability

Qualifying Relationship:

☐ Child ☐ Parent ☐ Grandchild ☐ Grandparent ☐ Sibling ☐ Spouse/Domestic Partner ☐ Designated Person (Must Have DP Form on File)

ABSENCE DATES AND PROPOSED INTERMITTENT LEAVE SCHEDULES

Absence Dates: From: _____ To: _____ **TOTAL HOURS**: _____
No intermittent leave for quarantine/isolation or symptoms unless teleworking. Attach schedule for allowed intermittent leaves.

Intermittent Leave Hours, if any:

_____ Hour(s) Per Day; _____ Day(s) Per Week From _____ To _____

Signature: _____ **Date:** _____

		Approve	Deny
Supervisor/Manager (Appointing Officer)		☐	☐
Personnel Officer			

cc: Official Employee Personnel Folder

Continued on Reverse

PUBLIC HEALTH EMERGENCY LEAVE REQUEST FORM

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

Government Ordered Quarantine/Isolation: I am subject to a Public Health Emergency recommendation or requirement that prevents me from going to work or teleworking.

Government Entity Issuing the recommendation or requirement: _____

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, 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 Symptoms and Seeking Diagnosis or Receipt of a Positive Medical Diagnosis: I am sick with symptoms and will receive testing or other diagnostic services, or I have received a positive medical diagnosis for an infectious, contagious, or communicable disease.

Provider/Clinic/Test Site Name: _____

Address: _____ City: _____ State: _____

Test/Exam Date: _____

☐ **It's not me, instead I'm taking care of a family member meeting these conditions, and I cannot work or telework.**

Leave for School/Childcare Provider Closure/Unavailability: 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 Public Health Emergency, 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) 14-17, or adult child age 18, or older.**

Air Quality Emergency: I am a member of a Vulnerable Population as defined in the PHEL Ordinance, and I primarily work outdoors.

(Medical Information below is optional for employees aged 60 or more.)

Health Care Provider's Name: _____

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

☐ My Public Health Emergency Leave Medical Certification is on file.

ACKNOWLEDGEMENT

I CERTIFY THAT MY ABSENCE REQUEST IS FOR THE PUBLIC HEALTH EMERGENCY RELATED REASON STATED ON THIS PUBLIC HEALTH EMERGENCY LEAVE REQUEST FORM.

I UNDERSTAND THAT LEAVE AND PAY APPROVED BECAUSE OF THE PUBLIC HEALTH EMERGENCY IS SUBJECT TO PROVISIONS IN THE PUBLIC HEALTH EMERGENCY LEAVE ORDINANCE, THE APPLICABLE DECLARATION OF EMERGENCY, 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:** _____