REQUEST FOR COVID-19 PAID SICK LEAVE

Effective through December 31, 2021

Employee Name: _____ **Department:** _____

Dean/Director: _____ **Position Title:** _____

Date Leave Begins/Began:_____ **Date Leave Ends:**_____

Hours Used:_____

I am unable to work from or work from home and request to use COVID-19 Paid Sick Leave for the following reason (check at least one):

☐	I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.
☐	I have been advised by a health care provider to self-quarantine related to COVID-19.
☐	I am experiencing COVID-19 symptoms and am seeking a medical diagnosis.
☐	I am caring for an individual subject to an order described in (1) or self-quarantineas described in (2)
☐	I am caring for my child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons: Child/Children Name(s): _____ School District Name: _____
☐	To attend a vaccination appointment or unable to work or work from home due to vaccine related symptoms.

Proof of eligibility may be requested for all options*

Employee's Signature:_____ Date:_____

Please submit a copy of this form to your immediate supervisor and Payroll at payroll@collegeofthedesert.edu .