County of San Benito

Human Resources Department

481 Fourth Street, Hollister, CA 95023 (831) 636-4000 Fax: (831)636-4010
email: humanresources@cosb.us www.sbchr.us

2022 COVID-19 Supplemental Paid Sick Leave Request

*This request is for employees who are unable to work or telework.

Employee Name:______________________________ Position Title: _____________________

Department/Agency: __________________________ Date of Request: ___________________

SUMMARY OF REQUEST

I am requesting COVID-19 Sick Leave for the following reason (check one):

- ☐ Subject to isolation period related to COVID-19 as defined by an order or guidelines of the State Department of Public Health, the federal Centers for Disease Control and Prevention, or a local health officer who has jurisdiction over the workplace.

- ☐ Due to a workplace exposure and subject to a quarantine for COVID-19 as defined by an order or guidelines of the State Department of Public Health, the federal Centers for Disease Control and Prevention, or a local health officer who has jurisdiction over the workplace.

- ☐ Attending an appointment to receive a vaccine for protection against contracting COVID-19.

- ☐ Experiencing symptoms related to a COVID-19 vaccine that prevent the employee from being able to work or telework.

I am requesting leave to begin on: _____________, 2022.

Date Leave Ends: _________________, 2022.

Total # of hours of 2022 Covid-19 Supplemental Paid Sick Leave requesting: _____________

I understand that:

1. I am bound by all the terms and conditions of the County's Leave of Absence Program and that the County has the right to grant or deny any request for a leave of absence or an extension thereof, subject by provisions of the Federal Family Medical Leave Act, the State Family Rights Act, the State Pregnancy Disability Leave rights, applicable collective bargaining agreements, leave policies of the San Benito County Personnel Policies and Procedures Handbook, and the San Benito County Family Care and Medical Leave Policy.

2. I may be required to make premium payments directly to the County while on leave of absence. If I fail to make payments on a timely basis, coverage under that benefit will be canceled until I return from leave and deductions resume. If the County mistakenly pays any premiums on my behalf, I agree to repay the County directly.

3. The failure to return to work on the day following the "Date Leave Ends" may be considered inexcusable absence without leave and subject to disciplinary action. I also understand that if I fail to report for duty within three consecutive work shifts beginning with the day following the "Date Leave Ends" I have entered on this form, the County may deem that I have voluntarily abandoned my job under Section 6.8.2 of the County of San Benito Personnel Policies and Procedures Handbook.

4. Failure to provide a complete and sufficient medical certification may result in a denial of my leave of absence request. I further understand that I may be required to provide periodic reports on my status and intent to return to work. I agree to notify BOTH, my supervisor/department and Human Resources of my availability to return to full or restricted duty if I am released by my doctor prior to the end of an approved medical leave of absence.

5. I attest that I am unable to work due to one of the reasons #1-4, as specified above.

I affirm that I have read, understand and agree to the terms of this request as stated above. By signing below, I certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Furthermore, I also understand that, the County may request documentation in relation to the leave request above.

Employee Signature:_____________________________________Date:___________________

For Human Resources ONLY

Application Status:

☐ Approved

☐ Denied

Comments:

Hours eligible for: _________________________

Authorizing Signature: _______________________________ Date: ________________