

## REQUEST FOR COVID-19 SUPPLEMENTAL PAID SICK LEAVE (SPSL)

### Senate Bill 114 (Chapter 4) Expanded

<b>Employee Name:</b>		<b>Employee ID:</b>		<b>Date Requested:</b>	
<b>Job Title:</b>		<b>Division/Department:</b>			
<b>Classification:</b>	<b>CBID:</b>	<b>Full-Time:</b>	<b>Part-Time:</b>	<b>Exempt:</b>	<b>Non-Exempt:</b>
<b>Supervisor Name:</b>		<b>Supervisor email/ext.:</b>			

To access this program, employees must complete and submit the signed request form to their campus Human Resources department **prior** to the start of SPSL. However, if time does not permit, employees may verbally request SPSL and follow up with a completed form.

**Each eligible employee may request up to 80 hours of Supplemental Paid Sick Leave (SPSL) to be used between January 1, 2022, and December 31, 2022. Unused SPSL has no value if an employee separates from CSU employment. Where leave usage restrictions apply, permissible reasons for leave are noted below.**

**PERMISSIBLE USE OF LEAVE**

Check Box(s)	Qualifying Reasons to Use of up to <b>40 hours (5 days)</b> Supplemental Paid Sick Leave (SPSL)
<input type="checkbox"/>	I am subject to a quarantine or isolation period related to COVID-19 as defined by federal, state, or local orders or guidelines.
<input type="checkbox"/>	I am advised by a health care provider to isolate or quarantine due to concerns related to COVID-19.
<input type="checkbox"/>	I am attending an appointment for myself or my family member to receive a COVID-19 vaccine or a vaccine booster. <b>[I have read the leave usage restrictions that may apply to vaccinations (including boosters) below in the next box.]</b>
<input type="checkbox"/>	I am experiencing symptoms, or caring for a family member experiencing symptoms, related to a COVID-19 vaccine or vaccine booster that prevents the employee from being able to work. <b>[If requested, I understand I must provide verification from a health care provider to use SPSL for this reason beyond 3 days / 24 hours). I further understand that the 3 day / 24 hour limitation applies to each vaccine or vaccine booster for me or my family member and includes the time used to get the vaccine or vaccine booster.]</b>
<input type="checkbox"/>	I am experiencing COVID-19 symptoms and seeking a medical diagnosis.
<input type="checkbox"/>	I am caring for a family member who is subject to a quarantine or isolation order or guideline or who has been advised to isolate or quarantine by a health care provider due to concerns related to COVID-19.
<input type="checkbox"/>	I am caring for a child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises.
Check Box	Qualifying Reason to Use of up to an <b>additional 40 hours (5 days)</b> Supplemental Paid Sick Leave (SPSL)
<input type="checkbox"/>	I have tested positive for COVID-19, or a family member that is under my care has tested positive for COVID-19. <b>[I acknowledge that I must submit to a COVID test on or after the fifth day following my initial COVID test and provide documentation of the result in order to return to work. I further acknowledge that I must provide a positive COVID-19 test for my family member upon request.]</b>

**Request for dates of SPSL**

Month	Dates Requested (Additional detail may be attached to this form. Exempt employees must use time in full day increments if not covered under FML.)	Total Number of Hours Requested	Total Number of Hours Used Prior to this Request	Total Number of Hours Remaining in Allotment
<b>Total Hours</b>				

Month: _____			Pay Period _____			
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				Total

Month: _____			Pay Period _____			
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				Total

Month: _____			Pay Period _____			
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				Total

**SIGNED AND AGREED BY:**

*To the best of my knowledge and belief, I certify that the facts stated within are accurate and in full compliance with SPSL requirements. I understand I must substantiate the reason for the leave in accordance with SPSL pursuant to SB 114, CSU policy and/or MOU.*

Employee Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CAMPUS APPROVAL**

*I    approve    do not approve the use of the Supplemental Paid Sick Leave (SPSL) as indicated above.*

Appropriate Administrator Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*I    approve    do not approve the use of the Supplemental Paid Sick Leave (SPSL) as indicated above.*

Human Resources Designee Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_