CAL STATE EAST BAY
HUMAN RESOURCES & PAYROLL SERVICES

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

Senate Bill 114 (Chapter 4)

| **Employee Name:** | | | **Employee ID:** |
|---|---|---|---|
| **Job Title:** | | **Division/Department:** | |
| **Classification:** | **CBID:** | **Full-Time:** ☐ **Part-Time:** ☐ | **Exempt:** ☐ **Non-Exempt:** ☐ |
| **Supervisor Name:** | | **Supervisor email/Ext.** | |
| **Date Requested:** | | **Date of Requested Extension (if applicable):** | |

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 <u>40 hours (5 days)</u> Supplemental Paid Sick Leave (SPSL)** |
|---|---|
| | I am subject to a quarantine or isolation period related to COVID-19 as defined by federal, state, or local orders or guidelines. |
| | I am advised by a health care provider to isolate or quarantine due to concerns related to COVID-19. |
| | I am attending an appointment for myself or my family member to receive a COVID-19 vaccine or a vaccine booster.<br><br>[I have read the leave usage restrictions that may apply to vaccinations (including boosters) below in the next box.] |
| | 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.<br><br>[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 or 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.] |
| | I am experiencing COVID-19 symptoms and seeking a medical diagnosis. |
| | 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. |
| | 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 <u>additional 40 hours (5 days)</u> Supplemental Paid Sick Leave (SPSL)** |
| | I have tested positive for COVID-19, or a family member that is under my care has tested positive for COVID-19.<br><br>[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.]. |

***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:_____

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**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 |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | **Total Hours** | | | |

**CAMPUS APPROVAL**

*I approve the use of the Supplemental Paid Sick Leave (SPSL) as indicated above.*

Appropriate Administrator Name: _____ Signature: _____Date: _____

Human Resources Designee Name: _____ Signature:_____ Date:_____