

REQUEST FOR SB 95 SUPPLEMENTAL PAID SICK LEAVE (SPSL) Coronavirus Pandemic (COVID-19)

Employee Name:		Employee ID:	
Job Title:		Division/Department:	
Classification:	CBID:	Full-Time: <input type="checkbox"/> Part-Time: <input type="checkbox"/>	Exempt: <input type="checkbox"/> Non-Exempt: <input type="checkbox"/>
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.

Each eligible employee may request up to 80 hours of SPCL (Supplemental Paid Sick Leave) to be used between January 1, 2021 and September 30, 2021. Unused SPSL has no value if an employee separates from CSU employment.

PERMISSIBLE USE OF LEAVE

Select at least One (1)	Qualifying Reasons to Use CSU Expanded Coronavirus Related Leave (SPSL)
	I am unable to work or telework due to a quarantine order from the appropriate agency.
	I am unable to work or telework because I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
	I am unable to work or telework because I need to attend an appointment to receive a vaccine for protection against contracting COVID-19.
	I am unable to work or telework because I am experiencing symptoms related to the COVID-19 vaccine that prevent me from being able to work.
	I am unable to work or telework due to experiencing symptoms of COVID-19 and seeking a medical diagnosis.
	The employee is caring for a family member as defined in subdivision (c) of Section 245.5, who is subject to an order or guidelines described in subparagraph (A) or who has been advised to self-quarantine, as described in subparagraph (B).
	The employee is caring for a child, as defined in subdivision (c) of Section 245.5, whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises.

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 CSU policies for SPSL requirements. I understand I may be asked to substantiate the reason for the leave in accordance with current Bargaining Unit MOU and/or CSU Policies.

Request for Dates of SPSL

Type of Leave	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			

Employee Name: _____ Signature: _____ Date: _____

CAMPUS APPROVAL

I approve the use of the temporary paid leave(s) as indicated above.

Appropriate Administrator Name: _____ Signature: _____ Date: _____

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

**Request for Dates of CSU SB 95 Supplemental Paid Sick Leave (SPSL)
Detail by Month**

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 _____		
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