

Supplemental Paid Sick Leave (SPSL) and SB 114 Leave Request Form

For COVID-19 Leave under Senate Bill (SB) 114 Only



Instructions:

All employees requesting to use paid leave for a qualified reason under Supplemental Paid Sick Leave (SPSL) and SB 114 Leave should complete the Employee's Statement portion of this form. The completed form should be forwarded to the departmental HR office. For additional information contact your Benefit Coordinator. The County of Monterey Board of Supervisors has approved SPSL provision under Senate Bill (SB) 114 and Assembly Bill (AB) 1522 from January 1, 2022 through December 31, 2022.

Employee's Statement

Print Name: _____ **ID Number:** _____ **Phone#** _____

I am requesting up to 40 hours of Supplemental Paid Sick Leave payable at 100% of regular pay up to \$511 per day or \$5,110 in the aggregate for the following reason related to COVID-19:

- 1) I am subject to a quarantine or 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 whose jurisdiction impacts County of Monterey employees.
- 2) I have been advised by a health care provider to isolate or self-quarantine due to concerns related to COVID-19.
- 3) I am attending an appointment to receive a vaccine or vaccine booster for protection against COVID-19.
- 4) I am attending an appointment for my family member to receive a vaccine or vaccine booster for protection against COVID-19.
- 5) I am experiencing symptoms related to a COVID-19 vaccine or vaccine booster that prevents me from being able to work or telework. (Not to exceed 24 hours per vaccine/booster including time used under reasons 3 and 4)
- 6) I am caring for a family member who is experiencing symptoms related to a COVID-19 vaccine or vaccine booster that prevents me from being able to work or telework. (Not to exceed 24 hours per vaccine/booster including time used under reasons 3 and 4)
- 7) I am experiencing symptoms of COVID-19 and I am seeking a medical diagnosis.
- 8) I am caring for a family member who is subject to an order or guidelines as described in absence reason 1 above or who has been advised to self-quarantine, as described in absence reason 2 above.
- 9) I am caring for my child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises.

Supporting Documentation Attached: Healthcare Provider Certification* School/daycare Closure Certification*

I am requesting up to an additional 40 hours of SB 114 Leave payable at 100% of regular pay up to \$511 per day or \$5,110 in the aggregate for the following reason related to COVID-19:

- I have tested positive for COVID-19 and have provided documentation of the test results
- My family member has tested positive for COVID-19 and have provided documentation of the test results

Required Supporting Documentation Attached: COVID-19 Test Results

Type of Leave: Continuous Leave Intermittent Leave

Dates Requested for Leave: _____ to _____ Return to Work: _____

Specify schedule: _____

If available, I request to integrate my accrued leave to receive 100% of my regular pay. Yes No

Employee Signature

Date

Human Resources:

Departmental HR Professional Name _____
Signature _____
Date

- Is Eligible for SPSL: _____ hrs. Is Eligible for SB 114 Leave: _____ hrs.
- Is NOT Eligible for SPSL Reason: _____ Is NOT Eligible for SB 114 Leave Reason: _____

*The County may not deny a leave under this provision for lack of supporting documentation.