Request for COVID-19 Supplemental Paid Sick Leave (SPSL) (Senate Bill 95)

Employee Name:			**Employee ID:**
Job Title:		**Division/Department:**	
Classification:	**CBID: Unit 3**	**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 are requested to complete and submit the signed request form to their campus Human Resources department prior to the start of Supplemental Paid Sick Leave (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 (10 days) of SPSL to be used between January 1, 2021 and December 31, 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 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 self-quarantine due to concerns related to COVID-19.
	I am attending an appointment to receive a COVID-19 vaccine.
	I am experiencing symptoms related to a COVID-19 vaccine.
	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 self-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.

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 Supplemental Paid Sick Leave, as indicated above.

Appropriate Administrator Name: ______________________________ Signature: _________________________Date: __________

Human Resources Designee Name: ______________________________ Signature:_________________________ Date:___________

<Campus Logo> Attachment B

Request for Dates of 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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