Davis County HOSPITAL & CLINICS

An Affiliate of MERCYONE

Request and Certification for DCHC COVID Paid Sick Leave

January 1, 2021 – March 31, 2021

Name: _____ Date: _____

Position Title: _____

Department: _____

Dates of leave requested (**scheduled to work**) and hours per day absent: _____

_____

Current contact information including home email and phone: _____

Reason for Leave:

For Self:

☐ #1. You are following a federal, state, or local quarantine or stay-at-home order

Name of government entity that issued the order_____

☐ #2. You are quarantined by a health care provider

Name of provider_____

☐ #3. You have COVID-19 symptoms and are seeking a diagnosis

Name of Provider_____

Note that you are required to promptly submit documentation regarding any need for leave. This may include a public notice or email of a school closure, any governmental order and/or medical certification. By submitting documentation, you are certifying that it is accurate and truthful. Submitting any inaccurate or untruthful information is considered to be gross misconduct. Failure to submit documentation will result in leave approval being denied.

This is a one-time benefit. If you qualified during the effective dates of the FFCRA (September 16, 2020 through December 31) and you have already exhausted the allotted 2 weeks leave, additional COVID Paid Sick Leave is not available.

Signature of employee: _____ Date: _____