

Request and Certification for DCHC COVID Paid Sick Leave

April 1, 2021 – April 30, 2021

Name: _____ Date: _____

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 this form regarding any need for leave. You will also be required to timely submit documentation such a note from your provider. 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) or COVID Paid Sick Leave (January 1, 2021 through March 31, 2021) and you have already exhausted the allotted 2 weeks leave, additional COVID Paid Sick Leave is not available with this leave.

* employee needs to notify HR when they notify their manager that they are not coming to work or leaving work early. Not notifying HR will disqualify employee from pay and having absence covered under COVID. EE will have to use PTO and receive occurrence.

This form should be emailed to: pyoung@dchc.org and bmccoy@dchc.org

Signature of employee: _____ Date: _____