City of Oxnard

Employee Request Form

Prospective COVID-19 Supplemental Paid Sick Leave ("SPSL")

TIMEKEEPERS: PAYROLL CODE 9V

Use this form If you are requesting SPSL after April 9, 2021

(Supervisors may complete this form on behalf of their employees if necessary)

Name: _____ Title: _____ Union: _____

Department/Division: _____

Current Address: _____ Date: _____

☐ Request for a leave of absence from _____ to _____ (return to work date)

Reason (check appropriate box):

☐ 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 ("CDPH"), the federal Centers for Disease Control and Prevention ("CDC"), or a local health officer who has jurisdiction over the workplace. The government agency that has issued the quarantine or isolation order is: _____

☐ I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. The name of the health care provider who has advised me to self-quarantine due to concerns related to COVID-19 is: _____.

☐ I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

☐ I am caring for a Family Member who is subject to a quarantine or isolation order or guidelines described above, or who has been advised to self-quarantine by a health care provider. The Family Member I am caring for is: _____ (state the relation to you of the Family Member you are caring for).

☐ 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. The name of the school or place of care that is closed or otherwise unavailable is: _____.

☐ I am attending an appointment to receive a vaccine for protection against contracting COVID-19. My vaccination appointment is on: _____ (date) at _____ (time).

☐ I am experiencing symptoms related to a COVID-19 vaccine that are preventing me from being able to work or telework.

☐ I am seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of, COVID-19 after I was exposed to COVID-19.

I certify that the above information is true and correct.

Employee Signature:_____ Date:_____Phone:_____

Human Resources Department:_____Date:_____