City of Oxnard

Employee Request Form

Retroactive COVID-19 Supplemental Paid Sick Leave (“SPSL”)

TIMEKEEPERS: PAYROLL CODE 9V

Use for Accrued Leave Taken Between January 1, 2021 - April 9, 2021

Name: ______________________________ Title: __________________________ Union: _____________

Department/Division: ____

Current Address: ____ Date: ______________

☐ Request for Retroactive SPSL Date(s):______________________Time(s):________________________

(If needed) Date(s):______________________Time(s):________________________

(If needed) Date(s):______________________Time(s):________________________

Reason (check appropriate box):

☐ I was 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 issued the quarantine or isolation order was: ____.

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

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

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

☐ I was caring for a Child whose school or place of care was closed or otherwise unavailable for reasons related to COVID-19 on the premises. The name of the school or place of care that was closed or otherwise unavailable is: ________________________________.

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

☐ I was experiencing symptoms related to a COVID-19 vaccine that prevented me from being able to work or telework. I experienced these symptoms on ___________________ (date(s)).

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By signing this form, I hereby acknowledge that the number of hours listed above accurately reflects all of the time during which I was unable to work or telework between January 1, 2021 and April 9, 2021, for one of the qualifying reasons for SPSL, as listed in the City's COVID-19 Comprehensive Policy and Protocol and under Labor Code § 248.2.

Once paid for such leave (if such the leave was unpaid) or reimbursed for other paid leaves used, I will hereby waive my right to seek further retroactive payments for unpaid SPSL on or after January 1, 2021 and on or before April 9, 2021.

If I have not exhausted my SPSL balance as a result of the above retroactive payment request, I understand that I may still qualify for SPSL in the future.

I certify that the above information is true and correct.

Employee Signature:______________________________ Date:____________________Phone:____________

Human Resources Department:______________________________Date:_________________