COLLEGE OF THE CANYONS

REQUEST FOR COVID-19 PAID SICK LEAVE

Employee Name:_____ Date of Request:_____

Department:_____ Position Title:_____

Expected Duration of Leave:_____ Date Leave Begins:_____

Work Schedule:_____

I am unable to work or telework and request to use COVID-19 Paid Sick leave for the following reason (check one):

_____ 1. I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19

_____ 2. I have been advised by a health care provider to self-quarantine related to COVID-19

_____ 3. I am attending an appointment to receive a vaccine for protection against contracting COVID-19

_____ 4. I am experiencing COVID-19 symptoms and am seeking a medical diagnosis

_____ 5. I am experiencing symptoms related to a COVID-19 vaccination that prevent me from being able to work or telework

_____ 6. I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2); or

_____ 7. I am caring for my child whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons.

(Proof of eligibility may be required)

Method of Leave Requested

_____ **A.** Consecutive Leave (Date Range):_____

Employee's Signature:_____ Date:_____

Please return a completed copy to Maria Calderon-Human Resources: Fax (661) 362-5570 or maria.calderon@canyons.edu

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