COVID-19 PAID SICK LEAVE REQUEST FORM –
FOR POST-VACCINE SIDE EFFECTS AND SYMPTOMS

(FAMILIES FIRST CORONAVIRUS RESPONSE ACT)

Name: _____

Telephone Number: _____

Department: _____

Supervisor: _____

Dates of Sick Leave Needed: _____

The Families First Coronavirus Response Act provides some employees with up to two weeks of Emergency Paid Sick Leave for certain reasons, when an employee is unable to work or telework because of the reason. Employees may request ***up to two days (15 hours)*** of Emergency Paid Sick Leave for post-vaccination side effects and symptoms when the employee does not feel well enough to work. Emergency Paid Sick Leave used for this reason will be counted toward the employee's total COVID Leave allotment of up to 10 days / 75 hours.

___I am experiencing post-vaccination side effects and symptoms

- If requesting paid sick leave for this reason, you must provide documentation supporting your request that includes:
    1. Copy of COVID-19 vaccine card

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I,_____, with my signature below, certify that I need paid sick leave because I am unable to work or telework for the above-indicated reason. I also certify that the documentation I provide in support of my need for paid sick leave is true, accurate, and legitimate. I also certify that I will provide notification as soon as my reason for paid sick leave is no longer effective. I also acknowledge that this request for paid sick leave, upon approval, will be counted toward my total COVID Leave allotment.

Signature:_____ Date: _____

Supervisor Approval _____ *Date*_____/_____/_____

*HR Approval*_____ *Date*_____/_____/_____

Updated 02.25.2021