California Supplemental Paid Sick Leave (SPSL) Certification

(Complete and return to your Agency/Department Human Resources contact.)

Employee Name:	Employee ID#:
Department:	Classification:
Personal Phone#:	Personal Email:
Name of Immediate Supervisor/Manager:	

SECTION 1

Complete a separate SPSL Certification form for each type of request (1., 2., or 3.) below.

I am requesting SPSL as follows:

☐ **1. Continuous Leave.** Begin Date: _____ End Date: _____.

☐ **2. Intermittent Leave.** Begin Date: _____ End Date: _____

Frequency: _____ hours per day and/or _____ days per week.

☐ **3. Retroactive Leave Adjustment.** I am requesting SPSL for eligible leave used between January 1, 2021 and March 28, 2021 and for my leave usage to be adjusted.

Complete this for options 2 or 3:

Dates	Time	Duration (# Hours)

***NOTE**: Intermittent leave is only allowed for items (1), (2), (5) or (6) if Teleworking.*
Intermittent leave is allowed for items (3), (4), and (7) for either On-Site work or Telework.

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SECTION 2

I certify that I am/was unable to work/telework and am/was eligible for the requested leave because:
(check applicable box)

☐ (1) I am/was subject to a Federal, State, or local quarantine or isolation period related to COVID-19.

Quarantine or Isolation Start Date: _____

☐ (2) I have/was been advised by my health care provider to self-quarantine due to concerns related to COVID-19.

Name of Provider: _____

☐ (3) I am/was attending an appointment to receive a vaccine for protection against contracting COVID-19.

☐ (4) I am/was experiencing symptoms related to COVID-19 vaccine that prevent me from being able to work or telework.

☐ (5) I am/was experiencing symptoms of COVID-19 and seeking a medical diagnosis.

☐ (6) I am/was caring for a family member who is/was subject to an order or guidelines as described in (1) or (2); family members include the employee's spouse, registered domestic partner, parent (including parents-in-law), child (regardless of age or dependency), grandparent, grandchild, and sibling.

Name of Family Member's Provider: _____

☐ (7) I am/was caring for my child because my child's school or place of care is/was closed or otherwise unavailable for reasons related to COVID-19 on the school/care premises.

Name(s) of Child(ren)	**Name of School/Childcare Provider**

SECTION 3 ***(Required for Processing)***

I request to (*select one*) ☐ supplement / ☐ not supplement SPSL with my own leave accruals.

NOTE*: This benefit pays up to $511 per day, $5,110 in aggregate, for up to 80 hours* (exception applies to active duty firefighters). Employees can supplement with their own leave accruals to make up the difference between the SPSL and their regular pay.*

I hereby acknowledge that the above is true and correct. I understand that if my circumstances change, I must immediately inform my Agency/Department Human Resources contact.

_____ _____

Employee Signature Date

For Agency/Department HR use only:

☐ Approved ☐ Denied	Date:
Reviewer Name:	Reviewer Signature: