



PLACER COUNTY HUMAN RESOURCES DEPARTMENT

COVID-19

Name: _____

Department: _____

Employee Request for Retroactive 2022 COVID-19 Paid Sick Leave (CPSL)

I, _____, certify that I am requesting retroactive compensation for CPSL between January 1, 2022 and February 18, 2022 because I was previously unable to work or telework, and was paid through the use of accrued leave such as sick leave, vacation, CTO, Floating Holiday, etc., and/or went unpaid for the following reason(s):

COVID-19 Paid Sick Leave #1:

I was subject to a Federal, State, or local quarantine or isolation order related to COVID-19. The government agency that issued the quarantine or isolation order was: _____ From: _____ To: _____

I was advised by a health care provider to self-quarantine due to concerns related to COVID-19. Name of health care provider: _____ From: _____ To: _____

I attended an appointment for myself or a qualifying family member* to receive a vaccine or vaccine booster for protection against contracting COVID-19. Vaccination Appointment is for [] Self [] Qualifying Family Member Relationship to qualifying family member (if applicable): _____ Vaccination Appointment Date: _____ Time: _____

I (or a qualifying family member* who required my care) experienced symptoms related to a COVID-19 vaccine or vaccine booster that prevented me from being able to work or telework. Individual who experienced symptoms was [] Self [] Qualifying Family Member Relationship to qualifying family member (if applicable): _____ From: _____ To: _____

I experienced symptoms of COVID-19 (e.g., fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and/or diarrhea) and was seeking a medical diagnosis. From: _____ To: _____

I provided care for a qualifying family member* who was subject to a Federal, State, or local quarantine or isolation order related to COVID-19 or was advised by a health care provider to self-quarantine due to concerns related to COVID-19. Relationship to qualifying family member: _____ From: _____ To: _____

I provided care for my child whose school or place of care was closed or otherwise unavailable for reasons related to COVID-19 on the premises. Name of child: _____ Name of school/placer of care: _____ From: _____ To: _____

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I was exposed to a positive COVID-19 case at work and excluded from the workplace pursuant to the Cal/OSHA Emergency Temporary Standards (3205 (C)(10) "COVID-19 Regulations").
From: _____ To: _____

COVID-19 Paid Sick Leave #2:

Dates Requesting CPSL #2 From: _____ To: _____

I tested positive for COVID-19 following a diagnostic test.

Date of diagnostic test with positive results: _____

I have attached the required documentation (such as a print out, text, email from testing facility indicating positive test results, or other contemporaneous verification).

I provided care for a qualifying family member who tested positive for COVID-19 following a diagnostic test.

Relationship to qualifying family member: _____

Date of diagnostic test with positive results: _____

I have attached the required documentation (such as a print out, text, email from testing facility indicating positive test results, or other contemporaneous verification).

**Qualifying family members include a child, parent, spouse or registered domestic partner, grandparent, grandchild, or sibling.*

By completing and submitting this form, I acknowledge the following:

I may be eligible for up to 40 hours of retroactive 2022 COVID-19 Paid Sick Leave #1 (pro-rated for part-time employees); as well as up to 40 hours of retroactive 2022 COVID-19 Paid Sick Leave #2 if I, or a qualifying family member who requires my care, tested positive for COVID-19, and I was unable to work or telework.

My request for retroactive CPSL will be reviewed, and that the amount of CPSL approved may be dependent upon providing valid documentation.

If I have not exhausted my CPSL balances as a result of the above retroactive CPSL request, I may still qualify for CPSL in the future.

Employee/Representative Signature: _____ Date: _____

To submit your request for CPSL Time Off – send your completed and signed form to the Human Resources Department along with any required supporting documentation (if applicable). Send electronic requests to CPSLRequests@placer.ca.gov. Email subject lines should include your department, first and last name. **Do not submit your request forms directly to your department.**