# REQUEST FOR ADDITIONAL TEMPORARY COVID-19 LEAVE

*ALL REQUESTS WILL BE REVIEWED BY GARY SCHMIDT FOR APPROVAL*

Employee Name: _____ Employee ID: _____

Dates of Requested Leave From: _____ Through: _____

I have exhausted my approved Temporary COVID-19 leave and am requesting additional leave.

I will be using this leave: ☐ Intermittent or ☐ Continuous Hours of Leave Requested: _____ *(up to 40 hours)*

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## REASON FOR REQUEST: *(Please check the reason for requesting leave.)*

You must provide the documentation that applies to the reason requested.

**I am unable to work or telework because:**

☐ **1. I have been advised by a health care provider to self-quarantine related to COVID-19.** (Time coded as COVID-19 Sick Leave.)

Please provide the name of the healthcare provider who advised you to self-quarantine due to concerns related to COVID-19: _____

Before returning to work, you must provide a release to return to work from a health care provider.

☐ **2. I am experiencing COVID-19 symptoms and seeking a medical diagnosis.** (Time coded as COVID-19 Sick Leave.)

*Leave is limited to the period of time that you are unable to work or telework because you are taking affirmative steps to obtain a medical diagnosis (e.g., time spent making, waiting for, or attending an appointment related to COVID-19) and the County may request appropriate medical documentation.*

Before returning to work, you must provide a release to return to work from a health care provider.

☐ **3. I am caring for an individual subject to an order described in (1) or self-quarantined as described in (2).** (Time Coded as COVID-19 Sick Leave.)

Please provide documentation from the health care provider who advised the individual being cared for to self-quarantine or documentation of contact tracing from a third party such as the Oregon Health Authority or a County Public Health Department.

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**In the event an employee experiences a negative reaction to the COVID-19 vaccine which prevents them from working, the employee should use their appropriate accrued leave to cover their absence.**

By adding my name below, I hereby certify that I am unable to work or telework because of the qualified reason stated above. I certify that this statement is true and accurate and understand that my employer is relying on my representations and that false representations may result in disciplinary action.

Employee Name/Signature: Date:

If you have questions, please call (503) 655-8550, option 1 or e-mail LeaveAdmin@clackamas.us.

Please return completed form to Clackamas County HR Leave Administration via one of the following:

Email: LeaveAdmin@clackamas.us
Fax: (503) 742-5419
Mail: Clackamas County
HR Leave Administration
2051 Kaen Rd., Suite 310
Oregon City OR 97045

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LEAVE REQUEST IS: ☐ APPROVED ☐ DECLINED

HOURS OF LEAVE APPROVED: _____

START DATE: _____ END DATE: _____

BY: _____ DATE: _____