COVID-19 Leave Self-Certification Form

Employee Name:

Department:

Supervisor Name:

I am requesting COVID-19 Leave for the following dates:

I am requesting COVID-19 Leave for the following COVID-19 Leave Reason (please check the correct box below):

☐ A healthcare provider, public official/public health authority, or the College has determined that my presence on campus would jeopardize the health of others because I have been exposed to or am exhibiting symptoms of COVID-19;

☐ I need to self-isolate because I have been diagnosed with or tested positive for COVID-19; or I need to seek medical care due to symptoms related to COVID-19;

☐ I need to care for a family member if a healthcare provider, public official/public health authority, or the family member's employer has determined the family member's presence in the community will jeopardize the health of others because the family member has been exposed to or is exhibiting symptoms of COVID-19; or the family member has been diagnosed with or tests positive for COVID-19 or needs to seek medical care due to symptoms related to COVID-19;

☐ I need to care for my child if the child's school or childcare provider is unavailable or closes due to precautions taken in response to COVID-19; or

☐ I need to get a COVID-19 vaccine or booster or recover from any related side effects of the vaccine or booster.

By signing below, I hereby certify that the statements contained herein are true and correct to the best of my knowledge and belief. I understand that if I knowingly make any false statement herein, I am subject to such penalties as may be prescribed by statute or ordinance.

Signed:

(Sign or type your name above to indicate your signature)

Date: