PROTECTED LEAVE APPLICATION FORM - COVID

Employee Name: ____________________ Date of Hire: ____________________

Dept/Division: ____________ IAFF: ☐ 40 hour ☐ 56 hour Work Phone: ____________________

Home Address: ____________________ City/Zip: ____________________

Contact Phone: ____________________ Last Day Worked: ____________________

Anticipated Leave Start Date: ____________________ End date: ____________________

REASON FOR PROTECTED LEAVE:

☐ 1) I am subject to a quarantine or isolation order by a federal, state or local authority related to COVID-19;

☐ 2) I have been advised by a healthcare provider to self-quarantine due to concerns related to COVID-19;

☐ 3) I am experiencing symptoms of COVID-19 and seeking medical diagnosis;

☐ 4) I am caring for an individual who is subject to quarantine/isolation order or have been advised by a healthcare provider to self-quarantine (this leave is not applicable to emergency services personnel).
Name of ill family member: ____________________ Relationship to employee: ____________________

☐ 5) I am caring for my child/ren whose school or place of care has been closed or the childcare provider is unavailable, due to COVID-19 precautions (this leave is not applicable to emergency services personnel).
Name of child/ren: ____________________

☐ 6) I am experiencing a substantially similar condition specified by Secretary of Health and Human Services (this leave is not applicable to emergency services personnel).

☐ By selecting this box, I am requesting to use my accrued leaves to supplement the 2/3rd pay I will receive while on protected leave for reasons #4, 5, or 6 above. Please use my leave in this order: #1)____________ #2)____________ #3)____________.

Attached is my supporting document(s) until such time as a medical certification can be obtained from OHA, CDC or primary physician. I understand that these documents may be required to be obtained after the epidemic has ceased. Prior to returning to work, you must obtain a full medical release from either your primary care physician or the City of Salem Health Hub.

I agree that if I fail to return to work at the end of the leave period, I may be required to reimburse the City for the City's share of provided health benefits during my leave in accordance with regulations. Finally, I understand that if I do not return to work on the date indicated above (or as applicable and agreed to by the City), my employment may be terminated by the City as of the date my leave expires.

Employee's Signature:____________________ Date: ____________________