

**2022 COVID-19 SUPPLEMENTAL PAID SICK LEAVE REQUEST**

DFW 274 (NEW 02/19/22)

All requests for 2022 COVID-19 Supplemental Paid Sick Leave (SPSL) must be completed and submitted by the manager/supervisor to [COVID-19LeaveSupport@Wildlife.ca.gov](mailto:COVID-19LeaveSupport@Wildlife.ca.gov) for final approval.

EMPLOYEE INFORMATION			
EMPLOYEE FULL NAME:		POSITION NUMBER:	
TIME BASE: <input type="checkbox"/> Full-Time OR <input type="checkbox"/> Intermittent OR <input type="checkbox"/> Part-Time _____ (indicate fraction)	REGION/BRANCH/DIVISION:		
INITIAL REQUEST <input type="checkbox"/> OR SUBSEQUENT REQUEST <input type="checkbox"/>		TOTAL HOURS REQUESTED:	
EMPLOYEE UNABLE TO TELEWORK: <input type="checkbox"/> YES OR <input type="checkbox"/> NO		RECOMMEND TO: <input type="checkbox"/> APPROVE OR <input type="checkbox"/> DENY	
SPSL CONDITION REQUESTED – CHECK APPROPRIATE BOX(ES) UNDER EACH CONDITION			
<p>For purposes of the conditions below, a family member includes a child, parent, spouse, registered domestic partner, grandparent, grandchild, or sibling.</p> <p>A child can include a biological, adopted, or foster child, a step-child, legal ward, or child to whom the employee stands in loco parentis. A parent includes a biological, adoptive, or foster parent, step-parent, or legal guardian of the employee or the employee's spouse or registered domestic partner or person who stood in loco parentis when the employee was a minor child.</p>			
<p><input type="checkbox"/> <b>CONDITION #1 – Employee subject to a quarantine or isolation period related to COVID-19 as defined by an order or guidance of the California Department of Public Health (CDPH), the federal Centers for Disease Control and Prevention (CDC), or a local public health officer who has jurisdiction over the workplace.</b></p>			
<p>Is the employee subject to quarantine, asymptomatic, and has not received a positive COVID-19 test? <input type="checkbox"/> Yes OR <input type="checkbox"/> No</p> <p>If yes, follow the directions to request Administrative Time Off (ATO) through the general ATO process found in <a href="#">COVID-19 ATO HRB Memo #22-004</a>. ATO for this reason does not count against the employee's SPSL entitlement.</p> <p>If no, provide reason for quarantine or isolation: _____</p> <p>Total hours requested: _____ Date(s) Requested: _____</p>			
<p><input type="checkbox"/> <b>CONDITION #2 - Employee is advised by a health care provider to isolate or self-quarantine due to a COVID-19 concern or tests positive.</b></p>			
<p>Employee was advised by a health care professional to <input type="checkbox"/> isolate OR <input type="checkbox"/> quarantine due to a COVID-19 concern or tests positive for COVID-19.</p> <p>Total hours requested: _____ Date(s) requested: _____</p> <p><i>Note: Depending on the employee's situation, it may be more beneficial to utilize the Additional SPSL (up to 40 hours) entitlement before utilizing the maximum entitlement of 40 hours under Conditions 1-7. Managers/supervisors must confirm which entitlement the employee is requesting to use.</i></p>			
<p><input type="checkbox"/> <b>CONDITION #3 – Employee is attending an appointment for themselves or a family member to receive a COVID-19 vaccine or vaccine booster.</b></p>			
<p>Is the appointment for the employee or a family member? <input type="checkbox"/> Employee OR <input type="checkbox"/> Family Member</p> <p>If the appointment is for the employee, follow the directions to request Administrative Time Off (ATO) through the general ATO process found in <a href="#">COVID-19 ATO HRB Memo #22-004</a>. ATO for this reason does not count against an employee's SPSL entitlement.</p> <p>If the appointment is for a family member, provide the following information for each family member:</p> <ul style="list-style-type: none"> <li>• Name and relationship of family member: _____                             <ul style="list-style-type: none"> <li><input type="checkbox"/> 1<sup>st</sup> Dose (date): _____ Hours requested (max. 2 hours): _____</li> <li><input type="checkbox"/> 2<sup>nd</sup> Dose (date): _____ Hours requested (max. 2 hours): _____</li> <li><input type="checkbox"/> Booster (date): _____ Hours requested (max. 2 hours): _____</li> </ul> </li> <li>• Name and relationship of family member: _____                             <ul style="list-style-type: none"> <li><input type="checkbox"/> 1<sup>st</sup> Dose (date): _____ Hours requested (max. 2 hours): _____</li> <li><input type="checkbox"/> 2<sup>nd</sup> Dose (date): _____ Hours requested (max. 2 hours): _____</li> <li><input type="checkbox"/> Booster (date): _____ Hours requested (max. 2 hours): _____</li> </ul> </li> </ul>			

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<b><input type="checkbox"/> CONDITION #4 – Employee is experiencing symptoms or is caring for a family member related to a COVID-19 vaccine or vaccine booster.</b>					
Is this for the employee or a family member? <input type="checkbox"/> Employee OR <input type="checkbox"/> Family Member					
If for a family member, provide name and relationship of family member: _____					
Total hours requested: _____ Date(s) requested: _____					
<b><input type="checkbox"/> CONDITION #5 - Employee is experiencing symptoms of COVID-19 and is seeking a medical diagnosis.</b>					
Total hours requested: _____ Date(s) requested: _____					
<b><input type="checkbox"/> CONDITION #6 - Employee is caring for a family member who is subject to an order or guidance under Condition #1 or who has been advised to isolate or quarantine under Condition #2.</b>					
Family member is under <input type="checkbox"/> quarantine OR <input type="checkbox"/> isolation					
Name and relationship of family member: _____					
If under quarantine, provide the following information and check all boxes that apply:					
Date of COVID-19 close contact exposure: _____					
<input type="checkbox"/> Family member is fully vaccinated					
<input type="checkbox"/> Family member is booster eligible*					
<input type="checkbox"/> Family member has received booster					
<input type="checkbox"/> Family member is not vaccinated					
*Booster eligible is defined as five months after the second dose of the Pfizer or Moderna vaccine or two months after the Johnson and Johnson vaccine.					
<b>Note:</b> Employee must provide family member vaccine and/or booster information.					
Total hours requested: _____ Date(s) requested: _____					
<b><input type="checkbox"/> CONDITION #7 - Employee is caring for a child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises.</b>					
Name and relationship to child: _____					
School or place of care closure dates due to a COVID-19 on the premises: _____					
Total hours requested: _____ Date(s) requested: _____					
<b><input type="checkbox"/> ADDITIONAL SPSL – UP TO AN ADDITIONAL 40 HOURS, FOR A MAXIMUM TOTAL ENTITLEMENT OF 80 HOURS</b>					
Has the employee or a family member tested positive for COVID-19? <input type="checkbox"/> Yes OR <input type="checkbox"/> No					
Is this for the employee or a family member? <input type="checkbox"/> Employee OR <input type="checkbox"/> Family Member					
If for the employee, has the positive COVID-19 been reported to CDFW as <a href="#">required</a> ? <input type="checkbox"/> Yes OR <input type="checkbox"/> No					
If for a family member, provide name and relationship of family member: _____					
Total hours requested: _____ Date(s) requested: _____					
<b>TO BE COMPLETED BY HUMAN RESOURCES BRANCH – EMPLOYEE WELLNESS SERVICES (EWS) UNIT</b>					
Date Received:		Employee Time Base:		Prior 2022 SPSSL Hrs. Used:	____ Hrs. OR <input type="checkbox"/> N/A
<b><input type="checkbox"/> APPROVED</b> Total Hours Approved for Conditions 1-7: _____ AND/OR Total Hours Approved for Additional SPSSL: _____					
<input type="checkbox"/> CONDITION 1: _____ hours			<input type="checkbox"/> CONDITION 5: _____ hours		
<input type="checkbox"/> CONDITION 2: _____ hours			<input type="checkbox"/> CONDITION 6: _____ hours		
<input type="checkbox"/> CONDITION 3: _____ hours			<input type="checkbox"/> CONDITION 7: _____ hours		
<input type="checkbox"/> CONDITION 4: _____ hours			<input type="checkbox"/> Additional SPSSL: _____ hours		
<input type="checkbox"/> DENIED	Reason for denial:				
EWS Approver (Print Name):				Date:	
Signature:					