



**COUNTY OF SAN DIEGO
PUBLIC HEALTH EMERGENCY REQUEST
EMERGENCY PAID SICK LEAVE**

Please complete and return this request to your Departmental Human Resources Officer – DHRO or Leave Coordinator.

E M P L O Y E E C O M P L E T E S	Employee Name _____	Department Name _____	PeopleSoft Employee ID # _____	Employee Phone # _____
	Employee email _____			
<p>Emergency Paid Sick Leave (EPSL) – I request to participate based on my inability to work or telework due to the following reason: # _____</p> <ol style="list-style-type: none"> 1. I am subject to federal, state, or local quarantine or isolation order related to COVID-19; 2. I have been advised by a health care provider to self-quarantine due to COVID-19 related concerns; 3. I am experiencing symptoms of COVID-19; and seeking a medical diagnosis; 4. I am caring for an individual who meets the specifications in [1] or [2] above; 5. I am caring for a son or daughter if the school or place of care has been closed or the child care provider is unavailable due to COVID-19 precautions; or 6. I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in Consultation with the Secretary of the Treasury and the Secretary of Labor. <p>*Compensation for sick leave granted for reasons [1], [2], or [3] above are to be based on your regular rate of pay but shall not exceed \$511/day or \$5,110 in total. *Compensation for reasons listed in [4], [5] or [6] above shall be 2/3 of the regular rate of pay and shall not exceed \$200/day or \$2,000 in total. *You do not have to use other leave balance before using EPSL. The EPSL leave is available for immediate use regardless of how long you have worked with the County.</p> <p>Employee's Signature _____ Date _____</p>				
DHRO Section	<p>Emergency Paid Sick Leave (EPSL) is:</p> <p align="center">Granted Not Granted</p> <p>If granted, send to Departmental Payroll Staff for tracking and processing.</p>		<p>_____ Signature of Appointing Authority (or designee)</p> <p>Print Name _____</p> <p>Date _____</p>	
E M P L O Y E E C O M P L E T E S	<p>FML Public Health Emergency Leave - I request to participate based on my inability to work or telework due to a need to care for a minor son or daughter because of a school/day care closure related to the public health crisis:</p> <p><input type="checkbox"/> 1. I elect to use Emergency Paid Sick Leave for the first 10 days: _____</p> <p><input type="checkbox"/> 2. I elect to use my own leave balances for the first 10 days: _____ Leave balances I would like to use are _____ in order listed.</p> <p><input type="checkbox"/> 3. I elect to go uncompensated for the first 10 days: _____</p> <p>Supplemental Pay - I request to supplement my salary to reach 100% of my regular pay using: Sick Vacation Other: _____</p> <p>Benefit Payments Agreement – Signature Required</p> <p>I understand that I will be required to pay my regular share of the insurance premiums. If my Family Medical Leave (FML) Public Health Emergency Leave is unpaid, those payments will be collected by way of payroll adjustments upon my return to work.</p> <p>If I do not return to work after taking FML, I will still be responsible for repayment of my health insurance premiums that were paid by the County on my behalf. My Department will coordinate the collection of any amount I owe through Revenue & Recovery.</p> <p>Employee's Signature _____ Date _____</p>			
	DHRO Sector	<p>The Employee has been actively employed 30 days or more:</p> <p>FML PHE is tentatively:</p> <p align="center">*Granted *Not Granted</p> <p>*Pending final review by the Department of Human Resources. Send form directly to DHRBenefits.FGG@sdcounty.ca.gov</p>		<p>_____ Signature of Appointing Authority (or designee)</p> <p>Print Name _____</p> <p>Date _____</p>

NOTICE OF EMPLOYEE RIGHTS AND OBLIGATIONS FAMILY MEDICAL LEAVE* (FML)

1. This is a notice to employees eligible for leave under the federal Family Medical Leave Act (FMLA) of their specific rights and obligations [pursuant to 29 C.F.R. Section 825.301(c)]. The County's FML policies and procedures are more fully set forth in County Compensation Ordinance Section 4.3.12 and Department of Human Resources Policy 505.
2. The FMLA leave you take will be deducted from your annual FMLA allotment and your annual California Family Rights Act (CFRA) allotment. This notice refers to family medical leave (FML) taken under these acts.
3. FML may be taken continuously or intermittently. If FML is taken intermittently, you are required to report to your supervisor when the leave is related to your FML situation.
4. If you are taking FML due to your own serious health condition or a serious health condition of a family member, you must provide medical certification on the Department of Labor form, WH-380-E or WH-380-F. If you do not submit a medical certification, FML may not be granted. Under certain circumstances, re-certification of the serious health condition may be required. Certification is not required for the purposes of bonding leave when taken during the initial one-year bonding period following the adoption, birth, or placement of a child.
5. FML is an unpaid leave of absence. An employee will be required to use any applicable paid leave balances (excluding Injury Leave) concurrently with the FML. Employees receiving State Disability Insurance – SDI benefits have the option to decline the use of County leave balances. Employees receiving benefits from a Short-Term (STD) or Long-Term (LTD) Disability plan have the option to decline the use of sick leave balances.
6. You will be required to pay your regular share of the insurance premiums. If your Family Medical Leave (FML) is unpaid, those payments will be collected by way of payroll adjustments upon your return to work. If you do not return to work after taking FML, you will still be responsible for repayment of health insurance premiums that were paid by the County on your behalf. Your Department will coordinate the collection of any amount owed through Revenue & Recovery.
7. When you are returning to work from approved FML for your own serious health condition, the department may request a note from your health care provider certifying that you are able to return to work, the date you can return, any limitations or restrictions, and their anticipated duration. If you do not return to work by the first working day following the conclusion of your FML, and you continue on some other form of County leave, the department may require you to complete a Fitness for Duty Evaluation by a County Evaluator prior to your return to work, pursuant to County Compensation Ordinance section 4.3.8.
8. If you return to work by the first working day following the conclusion of your FML, you are entitled to return to the same or an equivalent position. Should you exhaust your FML and continue on some other form of County unpaid leave, you may not be entitled to return to your position.

*These guidelines are applicable to Family Medical Leave and do not specifically reference Public Health Emergency (PHE). Please refer to the FML PHE policy for specific guidance in asking for Family Medical Leave as it relates to Public Health Emergency.