

COVID-19 Leave Request Form

Employee to Complete (Please Save This Form Prior to Filling Out)

Employee Name		W #	
Agency/Department			
Email Address		Phone #	
Start Date of Leave*		End Date of Leave*	
Total Hours			
Requested			
*Note: Leave must be used of	continuously and is prorated f	or part-time employees.	
COVID-19 Vaccination	n Status (Please check o	one):	
☐ I am fully vaccinated a on file prior to the first of	against COVID-19 and Hay of leave requested.	IR has received proof of	my vaccination status
☐ I have an approved me exemption status on file	edical or religious vaccin prior to the first day of l		s received proof of my
□ I do not meet either of 19 Leave.	these criteria. If this bo	x is checked, you are no	ot eligible for COVID
Check List of Required	Documentation		
	PCR (non-rapid) test da and no later than the last we request form.		
POSITIVE COVID-19 SUBMITTED TO HUN FOLLOWING THE P.	MAN RESOURCES BY	THE END OF THE P	PAY PERIOD
Acknowledgements			
	by submitting this requesty/ID-19 during the timefr		nable to work or

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Is one of the following	documents is on ti		wion to first day of lance
			·
Required Documentation	ion Check List	Data	Received by HR
	I .	OVID-19 Leave, prorated by FT	E for part-time employees.
FMLA Eligible?	□ Yes □ No	# Hours Avanable	
Leave # of Hours Requested		# Hours Available*	
Effective Date of		End Date of Leave	
□Approved □Not appr	roved		
To be completed by Hu	uman Resources:		
Employee Name (Print	ted) W#	Signature	Date
Andrewia comments	(optional).		
Additional comments (•	
provider to veri		vaccination status or a med his request I am authorizing n provided on this form t	ng my health care
understand that	ased on either full		
and that providing including, terming If eligibility is being understand that	ng false informationation.	oose to verify any informat n may result in disciplinary	1