

1. EMPLOYEE INFORM	MATION:
Employee's Name:	Dept:
I was off: Full-Time	Part-Time: Hours per Week Hours per Day Total Hours
From:(Must be between J	to
I was off work due to a Fede telework) full-time for one o	eral, State, or local quarantine or isolation order and certify that I was unable to work (or of the following reasons:
guidelines of the Cali local health officer w	Subject to quarantine or isolation period related to COVID-19 as defined by an order or fornia Department of Public Health, the Federal Centers for Disease Control and Prevention, a ith jurisdiction over the workplace, been advised by a healthcare provider to quarantine, or was -19 symptoms and seeking medical diagnosis.
	ly Member: Caring for a family member who was subject to a COVID-19 quarantine or isolation vised by a healthcare provider to quarantine due to COVID-19.
on the premises.	: Caring for a child whose school or place of care was closed or unavailable due to COVID-19 age of child (ren):
	chool or child care provider:
	Attending a vaccine appointment or could not work or telework due to vaccine-related
Retro Accrual Usage	I was off work between the dates of 1/1/2021 through 3/28/2021 and request my accrual balances be credited back, up to 80 hours, for accruals previously used for leave due to the reasons listed above.
Employee Acknowledge	ment (signature indicates the foregoing statements are true and correct):
Employee's Signature:	Date
Department Head/Desig Acknowledgement:	nee Date:
Personnel Director or D	esignee: Date:
For Official Use Only	