

SCS COVID RELIEF (SCSCR) LEAVE REQUEST

EMPLOYEE NAME: _____

SCHOOL/DEPARTMENT: _____

DATES REQUESTED: _____

Employee certifies that SCS COVID Relief (SCSCR) leave is requested for the following qualifying reason. Employee understands that SCSCR leave may be denied if they do not provide any medical excuses or supporting documentation that is requested by their immediate supervisor or the Superintendent. A MAXIMUM of 10 SCS COVID Relief days will be granted.

_____ Employee tests positive for COVID. Please provide copy of positive test result.

_____ Employee is caring for his/her child or immediate family member that resides in his/her home with a positive COVID illness. Please provide copy of positive test result or medical excuse from physician.

_____ Employee was directed to isolate by his/her immediate supervisor due to close contact exposure at school or work location and was following district guidelines such as wearing face coverings, social distancing, etc.

_____ Employee is required to quarantine by his/her physician. Please provide documentation from your physician.

_____ Employee is requesting up to two days of SCSCR leave to receive vaccine or to recover from the vaccine side effects. Please provide proof of vaccination or medical excuse. **These 2 days for vaccine & recovery are part of (NOT in addition to) the 10 SCS COVID Relief days.

The Superintendent or immediate supervisor may deny paid SCS COVID Relief leave in circumstances where the employee did not follow district guidelines such as wearing face coverings, social distancing, etc. or violated an isolation or quarantine order recommendation by the school, healthcare provider, or ADPH. This SCS COVID Relief policy will be constantly reviewed and may be modified and/or eliminated as needed.

Employee – printed name

Signature of Employee

Date

Signature of Supervisor

Date

9/7/2021