MIAMI-DADE COUNTY
HUMAN RESOURCES DEPARTMENT
REQUEST FOR COVID-19 PAID SICK LEAVE

SECTION I: EMPLOYEE INFORMATION

Last Name	First Name	MI	Employee ID Number

Job Title	Supervisor

Department	Division

Phone Number	Work Phone Number	Email:

SECTION II: REASON FOR LEAVE

To request emergency paid sick leave as provided per Resolution No. R-1002-21 - COVID-19 Paid Sick Leave please complete this form and submit it to your Department Personnel Representative as soon as possible. You may take up to 80 hours of paid sick leave for any combination of the qualifying reasons below through December 31, 2023.

☐ 1. The employee is subject to a federal, state, or local quarantine or isolation order

Name of Entity that gave Isolation Order: _____

☐ 2. The employee has been advised by a health care provider to self-quarantine

Name of healthcare provider: _____

☐ 3. The employee is experiencing symptoms associated with COVID-19 and is seeking a medical diagnosis

Name of healthcare provider: _____

☐ 4. The employee is caring for an individual for whom no other suitable care is available, and that individual: (1) is subject to a federal, state, or local quarantine or isolation order related to COVID-19; (2) has been advised by a health care provider to self-quarantine due to concerns related to COVID-19; or (3) is experiencing symptoms associated with COVID-19 and seeking a medical diagnosis

Name of Individual, Relationship to Employee: _____

☐ 5. The employee is caring for a child whose primary or secondary school or place of care has been closed (or whose childcare provider is unavailable) due to COVID-19 related reasons, and no other suitable care is available for that child.

Name of child(ren), age of child(ren), and name of school or daycare facility:

_____

☐ 6. The employee is experiencing any other substantially similar condition specified by the U.S. Department of Health and Human Services

☐ 7. The employee has been exposed to COVID-19 and is seeking or awaiting the results of a diagnostic test for, or a medical diagnosis of COVID-19.

☐ 8. The employee is experiencing or recovering from an injury, disability, illness, or condition related to obtaining immunization related to COVID-19. Proof of vaccination is required.

Anticipated Start Date of Leave	Anticipated End Date of Leave

	Print Name	Signature	Date
Employee			
Employee Supervisor			
Department Director or Designee			

Please send completed form to your Departmental Personnel Representative.

For use by Human Resources Only

Processed by: _____ **Audited by:** _____

HR/PTA/BL/11-03-2023