

**REQUEST FOR CSU Expanded COVID-19 Related (Paid) Leave (ECRL)
Coronavirus Pandemic (COVID-19)**

Employee Name:		Employee ID:	
Job Title:		Division/Department:	
Classification:	CBID:	Full-Time: <input type="checkbox"/> Part-Time: <input type="checkbox"/>	Exempt: <input type="checkbox"/> Non-Exempt: <input type="checkbox"/>
Supervisor Name:		Supervisor email/Ext.:	
Date Requested:		Date of Requested Extension (if applicable):	

To access this program, employees are requested to complete and submit the signed request form to their campus Human Resources department prior to the start of Expanded COVID-19 Related Leave (ECRL). However, if time does not permit, employees may verbally request ECRL and follow up with a completed form.

Each eligible employee may request up to 128 hours (16 days), 256 hours (32 days) for Teamsters-represented employees, of ECRL to be used between January 1, 2021 and December 31, 2021. Unused ECRL has no value if an employee separates from CSU employment.

PERMISSIBLE USE OF LEAVE

Select at least One (1)	Qualifying reasons to use 2021 COVID-19 Expanded COVID-19 Related Sick Leave
	I am subject to a quarantine or isolation period related to COVID-19 as defined by federal, state, or local orders or guidelines.
	I am advised by a health care provider to self-quarantine due to concerns related to COVID-19
	I am attending an appointment to receive a COVID-19 vaccine.
	I am experiencing symptoms related to a COVID-19 vaccine.
	I am experiencing COVID-19 symptoms and seeking a medical diagnosis.
	I am caring for a family member who is subject to a quarantine or isolation order or guideline or who has been advised to self-quarantine by a healthcare provider due to concerns related to COVID-19.
	I am caring for a child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises. If so, insert the name of school or place of care: _____

SIGNED AND AGREED BY:

To the best of my knowledge and belief, I certify that the facts stated within are accurate and in full compliance with CSU policies for ECRL requirements. I understand I may be asked to substantiate the reason for the leave in accordance with current Bargaining Unit MOU and/or CSU Policies.

Request for Dates of ECRL

Month	Dates Requested (Additional detail may be attached to this form. Exempt employees must use time in full day increments if not covered under FML.)	Total Number of Hours Requested	Total Number of Hours Used Prior to this Request	Total Number of Hours Remaining in Allotment
Total Hours				

Employee Name: _____ Signature: _____ Date: _____

Employees approved for leave under ECRL will be required to report leave in Absence Management CMS as follows:

Leave Code/Absence Name: PAL/FFCRA Add Comments: ECRL

Campus Approval

I approve the use of the Expanded COVID Related (Paid) Leave, as indicated above.

Appropriate Administrator Name: _____ Signature: _____ Date: _____

Human Resources Designee Name: _____ Signature: _____ Date: _____

Forward all completed requests to the Benefits Office at benefits@csus.edu

**Request for Dates of CSU Extended COVID-19 Relief (Paid) Leave (ECRL)
Detail by Month**

Month: _____				Pay Period _____		
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				Total

Month: _____				Pay Period _____		
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				Total

Month: _____				Pay Period _____		
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Month: _____				Pay Period _____		
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