CONEJO VALLEY UNIFIED SCHOOL DISTRICT
HUMAN RESOURCES DEPARTMENT
750 Mitchell Road, Newbury Park, CA 91320
Phone: (805) 498-4557 ♦ Email: CVUSDHRD@conejousd.org

REMOTE WORK AND LEAVE OF ABSENCE REQUEST FORM

Name (First, M, Last)	**Department/School**	☐ **Certificated** ☐ **Classified**
Administrator/Principal	**Email**	**Phone Number**
Job Classification/Title	**Position Assignment Term:** _____ **Hrs/Day** _____**Work Year**	**Request to span as follows:** **From:**_____ **To:** _____

REQUEST TYPE ☐ **REMOTE WORK** ☐ **LEAVE OF ABSENCE** ☐ **LEAVE OF ABSENCE (IF NO REMOTE WORK AVAILABLE)**

BASIS FOR REQUEST

COVID-19 RELATED ILLNESS/EXPOSURE

☐ **1. I am under federal, state, or local quarantine due to COVID-19.**
☐ **2. I am under self-quarantine under advice of health care provider, including a Public Health Agency due to potential exposure - exhibiting symptoms of COVID-19 and is seeking medical diagnosis.**
☐ **3. I am caring for an individual who is subject to a quarantine or isolation order, or has been recommended by a health care provider to self-quarantine.**
☐ **4. I am self-quarantined due to potential exposure, with ☐ some ☐ no illness symptoms.**
☐ **5. Other: _____**

MEDICAL VULNERABILITY TO COVID-19

☐ **1. I meet the criteria for medically vulnerable as identified by CDC and/or health care provider.**
☐ **2. I have a medically vulnerable family member in the household.**

CHILD CARE / ON-CAMPUS SCHOOL CLOSURE

☐ **Leave or remote work is requested in order to care/support a minor child who must access remote learning from home for all or part of the day.**

Name of Minor Child(ren) / age: (1)_____ (2) _____
Name of Child Care/School: (1) _____ (2) _____
☐ No other adult in the household ☐ 2nd parent is an essential worker/no remote work available ☐ other _____

REQUEST REQUIREMENTS:

(1) If you are specifying a reason for leave and/or remote work in either the COVID-19 illness or medically vulnerable category, **certification from a designated public health agency and/or health physician** is required to be submitted within five (5) business days of request. Certified clearance to return to work will be required for COVID-19
(2) You must submit a **Remote Work Plan** (if requesting remote work), specifying at-home work conditions and ability to complete essential and assigned job tasks without loss of efficiency and effectiveness. Provide separate letter with this form.

Employee Signature: _____ Date: _____

DEPARTMENT ADMINISTRATOR REMOTE WORK REVIEW

☐ Full Week ☐ Partial Week ____specify # of days ☐ Unable to accommodate without disruption to operation Administrator Signature: _____ Date: _____

HUMAN RESOURCES DEPARTMENT REVIEW

Leave Request Eligible For:

- ☐ **Emergency Paid Sick Leave (FFCRA)** _____
- ☐ **FMLA / EPFLCC (FFCRA)**
- ☐ **Sick Leave (Accrued)** ☐ **Extended Half-Pay / Differential Leave**
- ☐ **Vacation**
- ☐ **Catastrophic Leave Request Submission**

Remote Work Details: _____
Approved by: _____ **Date:** _____