# ALAMO HEIGHTS ISD COVID-19 LEAVE REQUEST FORM—

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| **Name** | **Employee ID** |
| **Department/campus** | **Position** |
| **AHISD Email** | **Phone number (cell)** |
| **Date** | **Duration of leave** *(specify dates requested)* |

For absences incurred from August 1st 2021 through the end of the school year2021-2022, AHISD offers up to 5 days of COVID Leave for pay continuation under the following conditions:

1. The employee
    - is fully-vaccinated against COVID at the time of the leave request **or** has a valid medical exemption from receiving the COVID vaccine, **and**
    - has been directed to quarantine for COVID-related reasons and has (or is actively seeking) a COVID diagnosis, **or** must care for an immediate family member incapable of self-care who is under quarantine for COVID-related reasons
2. Pay continuation during COVID leave will be the normal daily rate of pay for the employee's own quarantine, or 2/3rds the regular daily rate of pay if leave is taken to care for a family member in quarantine
3. This leave entitlement will expire on June 30th, 2022. Only absences on or before this date will be covered.

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I request leave for the following reason(s):

**Self**

___ I'm subject to a federal, state, or local quarantine or isolation order related to COVID-19.

Name, phone number, and email of entity requiring quarantine or isolation:

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___ I've been advised to self-quarantine by a health care provider.

Name, phone number, and email of health care provider requiring self-quarantine:

_____

___ I'm experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

Name, phone number, and email of health care provider:

_____

___ I'm expericing any other substantially-similar conditions specified by the U.S. Department of Health and Human Services.

**Care for other individual or child**

___ I'm unable to work in order to care for a minor son or daughter because their school is closed or child care is not available due to COVID-19.

Name, phone number, and email of school or child care facility: _____

Are you the only adult caring for the child(ren): _____yes _____no

Name and age of child(ren): _____

If the son or daughter is over the age of 14 describe special circumstance requiring the care:

_____

___ I'm unable to work in order to care for an individual subject or advised to quarantine or isolate.

Name of individual: _____ Relationship: _____

Name, phone number, and email of health care provider:

_____

**Intermittent Leave**

___ I'm requesting intermittent leave according to the following schedule:

_____

_____

**Designation** *(completed by HR Department and a copy provided to the employee)***:**

_____The employee qualifies for COVID leave.

_____The employee does not qualify for COVID leave.

_____Pay is normal rate of pay.

_____Pay is 2/3rds rate of pay.

***For office use only:***

Date of Employment _____

Medical certification provided _____Yes _____ No

Approved by:_____
Name and title

Date:_____