HUMAN RESOURCES
Illinois State University

Policy 3.1.49 COVID-19 Related Leave of Absence Application

Name: ____ University ID: ________________________

Address: ___________________________________ Contact Ph.: ____________________________

City, State, Zip: ____Work Ph.: ______________________

Department: ____________________ Mail Code: ___________ Supervisor: ______________________

Beginning Date for Leave: _____________ End Date of Leave:___________________

Last Day Worked: ___________________ Normal Work Schedule (Days & Times): __________________

If requesting leave due to the employee's inclusion in the group identified at higher risk for severe illness due to exposure to COVID-19, according to guidelines established by the CDC, or the inclusion of a member of the employee's household or an individual for whom the employee is responsible for care in these identified groups, refer to ***Section A****.*

If requesting leave due to the need to care for the employee's child because of the unavailability of school or eligible childcare, refer to ***Section B****.*

If requesting leave due to the need to quarantine or isolate or care for someone who must quarantine or isolate in accordance with CDC guidance related to COVID-19, receive or recover from a COVID-19 vaccination, or to await the results of a COVID-19 test, , refer to ***Section C****.*

Section A

At the direction of a medical provider and after the determination that full-time remote work is not an option for me, I am requesting leave because:

___ My medical condition places me in the group identified at higher risk for severe illness due to COVID-19 according to guidelines established by the CDC

___ The medical condition of someone in my household places that individual in the group identified at higher risk for severe illness due to COVID-19 according to guidelines established by the CDC

___ The medical condition of someone for whom I am responsible for care places that individual in the group identified at higher risk for severe illness due to COVID-19 according to guidelines established by the CDC

Leave Request Type: ___ Continuous ___ Reduced Schedule

If Reduced Schedule, please define requested schedule:____

____

Please initial the following statement:

___ I understand that this schedule requires the agreement of my department and can be reevaluated at any point during my leave of absence.

Section B

I am unavailable for full-time work on campus due to the closure of the child's school or place of care, change in school schedule and/or method of instruction, or the childcare provider is unavailable because of COVID-19 reasons and I need to care for:

___ The employee's child under the age of 18,

___ A child under the age of 18 for whom the employee has legal guardianship,

___ A child who has been placed with the employee for foster care,

___ The employee's child who is over the age of 18 but requires assistance with activities of daily living as defined by the Americans with Disabilities Act

.

Name of Child: ______________________________________ Date of birth: _______________________

Child's School: ______________________________________Closure Dates: ______________________

Eligible Child Care Provider: ________________________ Dates Unavailable: _____________________

Please initial the following statements:

___ I certify that my presence during the timeframe of my requested leave is necessary to provide care for the above-named child (children).

If you are requesting leave to care for a child older than age 14 during daylight hours, please submit your justification of why this child requires your care during those hours.

Leave Request (please see Policy 3.1.49 for permitted usage)

Type: ___ Continuous ___ Reduced Schedule ___ Intermittent

If Reduced Schedule or Intermittent, please define requested schedule:

____

____

Please initial the following statements:

___ I understand that this schedule requires the agreement of my department and can be reevaluated at any point during my leave of absence.

Section C

Please initial the following statements:

___ I am unavailable for full-time work on campus due to one of the qualifying reasons below.

Please mark the reason that applies to your leave request.

___ (1) The employee is subject to a Federal, State, or local quarantine or isolation order related to COVID-19.
Provide official documentation, if available, and
Name of the governmental entity ordering quarantine: ______________________________________

___ (2) The employee has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
Provide official documentation, if available, and
Name of the health care provider ordering quarantine: ______________________________________

___ (3) The employee is experiencing symptoms of COVID-19 and is seeking a medical diagnosis.
Provide official documentation, if available, and
Name of the health care provider contacted to seek diagnosis: _________________________________

___ (4) The employee is caring for an individual who is either:
1) Subject to a Federal, State, or local quarantine or isolation order related to COVID-19, or
2) Has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

Provide official documentation, if available, and Name of the governmental entity or health care provider

ordering quarantine: ____

Name of the individual: ______________________________Relationship: _______________________

___ (5) The employee requires time away from work to obtain an immunization related to COVID-19.
Provide proof of immunization, and
Location, date, and time of immunization appointment(s):

___ (6) The employee is recovering from an injury, disability, illness, or condition related to the COVID-19 immunization.
Provide proof of immunization.

___ (7) The employee is seeking or awaiting the results of a COVID-19 test or diagnosis because either the employee has been exposed to COVID-19 or the employer has requested such test or diagnosis.
Provide official test or diagnosis results.

Leave Type: Continuous Only

Nelson Smith Building 101 Campus Box 1300 Normal, IL 61790-1300

(309) 438-8311 Fax: (309) 438-7421 Email: hrbenefits@ilstu.edu

Please sign your initials to certify that you have read and understand each section below.

___ I understand that during this leave I will be required to use all available benefit time and will be granted temporary access to the Extended Illness benefit, if available, in accordance with usage as defined in Policy 3.2.7 Sick Leave.

___ I understand that the dates I have requested for my begin and end date of leave for a leave reason in Sections A or B may not be changed without approval from my department. A request to begin or end a leave on a date other than the original date may be subject to the availability of suitable work based on my department's needs at the time of my request.

___ I understand that I will be required to submit documentation to Human Resources substantiating my need for leave as defined in Policy 3.1.49 COVID-19 Related Leave of Absence within 15 days of my requested leave begin date. If it is found that I have falsified my need for leave, my leave may be denied and/or I may be subject to disciplinary action up to and including termination.

___ I understand that if my leave continues beyond the exhaustion of my payable benefit time that I will be placed on an unpaid leave of absence and benefit accruals will cease. At the same time, if I am enrolled with the State of Illinois Group Insurance Program, I will be placed on a Personal Leave of Absence with Central Management Services (CMS) and billed directly for any insurance premiums which will be calculated, in accordance with CMS rules, at the full cost of coverage with no employer contribution.

___ I understand that when applying for the benefit, I am responsible for following my department's call-in procedures until approval is received.

___ I understand that information and updates regarding my request for COVID-19 Related Leave of Absence will be provided through my Illinois State University email account (xxxxxx@ilstu.edu). It is my responsibility to ensure that my email is active and remains active while on leave. If I require any assistance with my email notifications, I am responsible for contacting the Technology Support Center at 309-438-HELP (4357) and requesting assistance.

___ I understand that while using COVID-19 Related Leave of Absence, I will be required to furnish Human Resources with periodic reports of my status and intent to return to work when requested.

___ I understand that if I requested leave for my own personal risk of exposure to COVID-19 as documented by my medical provider that I must provide a release to return to work from my medical provider to Human Resources before returning to work. I understand that I CANNOT return to work without a release from Human Resources.

I certify that I have read and initialed each section above. I understand that I am required to provide appropriate documentation to substantiate my need for the above leave.

Applicant's Signature: ____ Date: ________________