CITY OF FOLEY – Employee Paid COVID Sick Leave Request

Employees requesting leave time due to COVID 19 diagnosis after receiving vaccination must complete this form. Please submit your completed form, your work excuse, and your voluntary proof of vaccination to HR for processing.

Employee Name:	
Employee Home Address:	**E-mail:**
Home Phone Number:	**Cell Phone Number:**
Anticipated Begin Date of Leave:	**Expected Return to Work Date:**

Reason for Leave:

	PAY CODE	DESCRIPTION
☐	**COVID-19-8**	**I am requesting leave due to a COVID 19 diagnosis after receiving a previous vaccination.**

****Prior to returning to work, you will be required to submit a return to work excuse from your diagnosing physician/medical professional.**

I certify that the above information is accurate and complete and I understand that providing false or misleading information is subject to discipline up to and including termination.

Employee Signature: _____ **Date:** _____

Human Resources Approval: _____ **Date:** _____

☐ **Proof of Vaccination Received**

☐ **Work Excuse Received**

☐ **Leave Request Approved**

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