CITY OF TORRANCE
INTEROFFICE COMMUNICATION

Date: April 13, 2021

TO: **All City of Torrance Employees**

FROM: **Aram Chaparyan, City Manager**

SUBJECT: **Administrative Policy Concerning 2021 COVID-19 Supplemental Paid Sick Leave**

California Governor Newsom signed into state law Senate Bill 95 (COVID-19 Supplemental Paid Sick Leave), effective March 29, 2021. The law provides covered employees up to 80 hours of COVID-19 related sick leave January 1, 2021 – September 30, 2021. All City of Torrance employees are covered under this law, and the amount of supplemental paid sick leave available depends on your status as a full-time or part-time / recurrent employee.

This Administrative Policy is effective April 13, 2021, and paid leave benefits provided are retroactive to January 1, 2021. Below you will find information that summarizes the COVID-19 supplemental paid sick leave available for qualified reasons.

QUALIFYING REASONS FOR USE OF COVID-19 SUPPLEMENTAL PAID SICK LEAVE

Covered employees who are unable to work or work from home may use COVID-19 Supplemental Paid Sick Leave for any one of the following seven qualifying reasons:

1. Is subject to a quarantine or isolation period related to COVID-19 as defined by an order or guideline of the California Department of Public Health, the Centers for Disease Control and Prevention, or a local health officer who has a jurisdiction over the workplace.
2. Has been advised by a health care provider to self-quarantine due to concerns related to COVID-19.
3. Is attending an appointment to receive a vaccine for protection against contracting COVID-19.
4. Is experiencing symptoms related to a COVID-19 vaccine that prevent the employee from being able to work or work-from-home.
5. Is experiencing symptoms of COVID-19 and seeking a medical diagnosis.
6. Is caring for a family member who is subject to an order or guidelines described in #1 above, or who has been advised to self-quarantine described in #2 above.
7. Is caring for a child whose school or place of care is closed or otherwise unavailable for reasons related to COVID-19 on the premises.

PAID LEAVE FOR COVERED EMPLOYEES

- **Full-Time Employees**: 80 hours of paid leave are available for covered full-time employees through September 30, 2021. Because of their shift schedule, full-time firefighters may be entitled to more than 80 hours.

- **Part-Time Employees**: Part-time and recurrent employees are eligible for up to two weeks of pay. The available hours of COVID-19 Supplemental Paid Sick Leave is calculated as such:
    - Normal Schedule: Total number of hours normally scheduled in a two (2) week period.
    - Variable Schedule: 14 times the average number of hours worked each day over the six (6) months preceding use of SPSL or entire period if employee has not worked for at least six (6) months.

Use of COVID-19 Supplemental Paid Sick Leave must be for one of the seven reasons enumerated above. The maximum benefit is $511 per day and $5,110 in total for 2021 COVID-19 Supplemental Paid Sick Leave.

TO USE COVID-19 SUPPLEMENTAL PAID SICK LEAVE ON OR AFTER APRIL 13, 2021

If you require use of COVID-19 Supplemental Paid Sick Leave for a qualified reason, you may complete the attached **Employee Request Form for Prospective COVID-19 Supplemental Paid Sick Leave**. You may also orally request COVID-19 Supplemental Paid Sick Leave from your supervisor by following your Department's procedures for requesting sick leave. Supervisors are responsible for completing this form if the employee is making an oral request.

TO USE COVID-19 SUPPLEMENTAL PAID SICK LEAVE RETROACTIVELY JANUARY 1, 2021 – APRIL 13, 2021

If you are requesting COVID-19 Supplemental Paid Sick Leave retroactively for leave taken on or after January 1, 2021 and prior to April 13, 2021, you may complete the attached **Employee Request Form for Retroactive COVID-19 Supplemental Paid Sick Leave**. You may also orally request COVID-19 Supplemental Paid Sick Leave from your supervisor. Supervisors are responsible for completing this form if the employee is making an oral request.

If you are covered by one of the seven qualifying reasons for use of COVID-19 Supplemental Paid Sick leave, you may request retroactive use of COVID-19 Supplemental Paid Sick Leave for one of the following reasons for the time period of January 1, 2021 – April 13, 2021:

1. You were unpaid for the leave.
2. You accrued a negative sick leave balance.
3. You used accrued sick, vacation, compensatory, vacation comp or police annual leave time.

Following submission of your request, your supervisor will provide you with the number of hours of retroactive COVID-19 Supplemental Paid Sick Leave to which you are entitled. Please complete the attached **Employee Acknowledgement Form for Retroactive Request for COVID-19 Supplemental Paid Sick Leave** and submit to your supervisor.

ELIMINATION OF NEGATIVE SICK LEAVE ACCRUALS

Prior to the implementation of this Administrative Policy, employees were allowed to accrue a negative sick leave balance for a number of reasons related to COVID-19. With the implementation of this Administrative Policy, accruals of negative sick leave balances will no longer be allowed.

Please stay safe and healthy!

Aram Chaparyan
City Manager

Attachments: A) State of California, Department of Industrial Relations: 2021 COVID-19 Supplemental Paid Sick Leave Poster

B) Employee Request Form for Prospective COVID-19 Supplemental Paid Sick Leave

C) Employee Request Form for Retroactive COVID-19 Supplemental Paid Sick Leave

D) Employee Acknowledgement Form for Retroactive Request for COVID-19 Supplemental Paid Sick Leave

2021 COVID-19 Supplemental Paid Sick Leave

Effective March 29, 2021

Covered Employees in the public or private sectors who work for employers with more than 25 employees are entitled to up to 80 hours of COVID-19 related sick leave from January 1, 2021 through September 30, 2021, immediately upon an oral or written request to their employer. If an employee took leave for the reasons below prior to March 29, 2021, the employee should make an oral or written request to the employer for payment.

A covered employee may take leave *if the employee is unable to work or telework for any of the following reasons:*

- Caring for Yourself: The employee is subject to quarantine or isolation period related to COVID-19 as defined by an order or guidelines of the California Department of Public Health, the federal Centers for Disease Control and Prevention, or a local health officer with jurisdiction over the workplace, has been advised by a healthcare provider to quarantine, or is experiencing COVID-19 symptoms and seeking a medical diagnosis.
- Caring for a Family Member: The covered employee is caring for a family member who is subject to a COVID-19 quarantine or isolation period or has been advised by a healthcare provided to quarantine due to COVID-19, or is caring for a child whose school or place of care is closed or unavailable due to COVID-19 on the premises.
- Vaccine-Related: The covered employee is attending a vaccine appointment or cannot work or telework due to vaccine-related symptoms.

Paid Leave for Covered Employees

- 80 hours for those considered full-time employees. Full-time firefighters may be entitled to more than 80 hours, caps below apply.
  - For part-time employees with a regular weekly schedule, the number of hours the employee is normally scheduled to work over two weeks.
  - For part-time employees with variable schedules, 14 times the average number of hours worked per day over the past 6 months.
- Rate of Pay for COVID-19 Supplemental Paid Sick Leave: Non-exempt employees must be paid the highest of the following for each hour of leave:
  - Regular rate of pay for the workweek in which leave is taken
  - State minimum wage
  - Local minimum wage
  - Average hourly pay for preceding 90 days (not including overtime pay)
- Exempt employees must be paid the same rate of pay as wages calculated for other paid leave time.

Not to exceed $511 per day and $5,110 in total for 2021 COVID-19 Supplemental Paid Sick leave.

Retaliation or discrimination against a covered employee requesting or using COVID-19 supplemental paid sick leave is strictly prohibited. A covered employee who experiences such retaliation or discrimination can file a claim with the Labor Commissioner's Office. Locate the office by looking at the list of offices on our website (http://www.dir.ca.gov/dlse/DistrictOffices.htm) using the alphabetical listing of cities, locations, and communities or by calling 1-833-526-4636.

This poster must be displayed where employees can easily read it. If employees do not frequent a physical workplace, it may be disseminated to employees electronically.

CITY OF TORRANCE

EMPLOYEE REQUEST FORM FOR COVID-19 SUPPLEMENTAL PAID SICK LEAVE ("SPSL")

Please complete and return the following form to your immediate supervisor if you are requesting COVID-19 Supplemental Paid Sick Leave ("SPSL"). You may also orally request SPSL from your supervisor or by following your Department's procedures for requesting other forms of sick leave.

NAME: _____ ID#: _____ HIRE DATE: _____

POSITION: _____ DEPARTMENT: _____ SUPERVISOR: _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: _____ EMAIL: _____

I am requesting SPSL because I am unable to work or telework for the following reason:

☐ I am subject to a quarantine or isolation period related to COVID-19 as defined by an order or guidelines of the State Department of Public Health ("CDPH"), the federal Centers for Disease Control and Prevention ("CDC"), or a local health officer who has jurisdiction over the workplace. The government agency that has issued the quarantine or isolation order is: _____ (e.g., state, county, city).

☐ I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. The name of the healthcare provider who has advised me to self-quarantine due to concerns related to COVID-19 is: _____.

☐ I am attending an appointment to receive a vaccine for protection against contracting COVID-19. My vaccination appointment is on: _____ (date) at _____ (time).

☐ I am experiencing symptoms related to a COVID-19 vaccine.

☐ I am experiencing symptoms of COVID-19 and am seeking a medical diagnosis.

☐ I am caring for a Family Member who is subject to a quarantine or isolation order or guidelines described above, or who has been advised to self-quarantine by a health care provider. The Family Member I am caring for is: _____ (state the relation to you of the Family Member you are caring for).

☐ 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. The name of the school or place of care that is closed or otherwise unavailable is: _____.

I am requesting SPSL beginning on: _____ I expect to use SPSL until: _____

_____ _____
Employee's Signature Date

Note to Supervisor: If this is an oral request, please complete the information below:
Date Oral Request Made by Employee: _____

_____ _____
Supervisor's Signature Date

CITY OF TORRANCE

Supervisor, please retain a copy for your records and interoffice the original to Human Resources.

Human Resources:

Signature of Human Resources Representative: _____

Date Request Received by Human Resources: _____

Comments:

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CITY OF TORRANCE

EMPLOYEE REQUEST FORM FOR RETROACTIVE COVID-19 SUPPLEMENTAL PAID SICK LEAVE

Please complete and return the following form to your immediate supervisor if you are requesting COVID-19 Supplemental Paid Sick Leave ("SPSL") retroactively for leave taken on or after January 1, 2021 and prior to April 13, 2021. You may also orally request retroactive SPSL payment from your supervisor.

NAME: _____ ID#: _____ HIRE DATE: _____

POSITION: _____ DEPARTMENT: _____ SUPERVISOR: _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: _____ EMAIL: _____

I am requesting retroactive payment; reimbursement of a negative sick leave balance; or reimbursement of used accrued sick, vacation, compensatory, vacation comp, or police annual leave time for SPSL because I was previously unable to work or telework for the following reason(s) on or after January 1, 2021 and prior to April 13, 2021:

☐ I was subject to a quarantine or isolation period related to COVID-19 as defined by an order or guidelines of the State Department of Public Health ("CDPH"), the federal Centers for Disease Control and Prevention ("CDC"), or a local health officer who has jurisdiction over the workplace. The government agency that has issued the quarantine or isolation order was: _____ (e.g., state, county, city).

☐ I was advised by a health care provider to self-quarantine due to concerns related to COVID-19. The name of the healthcare provider who advised me to self-quarantine due to concerns related to COVID-19 is: _____.

☐ I attended an appointment to receive a vaccine for protection against contracting COVID-19. My vaccination appointment was on: _____ (date) at _____ (time).

☐ I was experiencing symptoms related to a COVID-19 vaccine.

☐ I was experiencing symptoms of COVID-19 and was seeking a medical diagnosis.

☐ I was caring for a Family Member who was subject to a quarantine or isolation order or guidelines described above, or who had been advised to self-quarantine by a health care provider. The Family Member I was caring for is: _____ (state the relation to you of the Family Member you are caring for).

☐ I was caring for a Child whose school or place of care was closed *or* otherwise unavailable for reasons related to COVID-19 on the premises. The name of the school or place of care that was closed or otherwise unavailable is: _____.

I am requesting payment or reimbursement for COVID-19 Supplemental Paid Sick Leave that I took for this qualifying reason beginning on _____ and ending on _____.

The dates listed above must be January 1, 2021 or after, and prior to April 13, 2021. If the dates you are requesting SPSL is on or after April 13, 2021, please fill out the ***Employee Request Form for Prospective COVID-19 Supplemental Paid Sick Leave****.*

_____ _____

Employee's Signature Date

Note to Supervisor: Please confirm accuracy of leave usage with timecards in ADP.

If this is an oral request, please complete the information below:

Date Oral Request Made by Employee: _____

_____ _____

Supervisor's Signature Date

CITY OF TORRANCE

Supervisor, please retain a copy for your records and interoffice the original to Human Resources.

Human Resources:

Signature of Human Resources Representative: _____

Date Request Received by Human Resources: _____

Comments:

_____

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_____

CITY OF TORRANCE

EMPLOYEE ACKNOWLEDGEMENT FORM FOR RETROACTIVE REQUEST FOR COVID-19 SUPPLEMENTAL PAID SICK LEAVE

Please complete and return the following form to your immediate supervisor after the Torrance has provided you with a calculation of the number of hours of retroactive COVID-19 Supplemental Paid Sick Leave ("SPSL") to which you are entitled based upon your request for such leave taken on or after January 1, 2021 and prior to April 13, 2021.

NAME: _____ ID#: _____ HIRE DATE: _____

POSITION: _____ DEPARTMENT: _____ SUPERVISOR: _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

PHONE: _____ EMAIL: _____

Date of Request for Retroactive SPSL: _____

Single Qualifying Leave Period:
Fill out this section *only* if you requested retroactive payment for one continuous period. If you requested SPSL for multiple, non-continuous periods, do not fill out this section, but complete the following section of this form.

I requested SPSL retroactive payment for qualifying reason(s) that began on _____ and ended on _____.

Multiple Qualifying Leave Periods:
Fill out this section if you requested retroactive payment for multiple qualifying periods. Complete for as many qualifying periods as you are seeking retroactive payment.

I requested SPSL retroactive payment for qualifying reasons for the following dates (only fill in as many fields as applicable):

1. Qualifying reasons that began on _____ and ended on _____.
2. Qualifying reasons that began on _____ and ended on _____.
3. Qualifying reasons that began on _____ and ended on _____.
4. Qualifying reasons that began on _____ and ended on _____.
5. Qualifying reasons that began on _____ and ended on _____.

On _____ *(Date)*, the City of Torrance advised me that I was eligible for _____ *(Insert Number of Hours)* hours of retroactive SPSL**,** in response to my request for retroactive SPSL payment or reimbursement of a leave account.

By signing this form, I hereby acknowledge that the number of hours listed above accurately reflects **all** of the time during which I was unable to work or work-from-home on or after January 1, 2021 and prior to April 13, 2021, for one of the seven qualifying reasons for SPSL, as listed in the City of Torrance's Administrative Policy Concerning COVID-19 Supplemental Paid Sick Leave.

Once paid for such leave (if such the leave was unpaid) or reimbursed for other paid leaves used, I will hereby waive my right to seek further retroactive payments for unpaid SPSL on or after January 1, 2021 and on or before April 13, 2021.

CITY OF TORRANCE

If I have not exhausted my SPSL balance as a result of the above retroactive payment request, I understand that I may still qualify for SPSL in the future.

_____ _____
Employee's Signature Date

Supervisor, please retain a copy for your records and interoffice the original to Human Resources.

Human Resources:

Signature of Human Resources Representative: _____

Date Request Received by Human Resources: _____

Comments:

_____

_____

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_____