



PANDEMIC AFFIDAVIT

City of Stephenville Pandemic or Public Health Event Leave

For the purposes of this affidavit, any pandemic or public health crisis classified as an emergency, declared emergency, disaster, or declared disaster will be referred to as an "Emergency".

As a full-time employee of the City, working a minimum of forty (40) hours per week I hereby attest and affirm the following (initial where applicable):

____ I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19.

____ I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19.

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

____ I am caring for an individual who is subject to an order as described in subparagraph (1) or has been advised as described in paragraph (2) of FFCRA.

____ I am caring for a son or daughter of such employee if the school or place of care of the son or daughter has been closed, or the childcare provider of such son or daughter is unavailable, due to COVID-19 precautions.

____ I am experiencing any other substantially similar condition specified by the Secretary of Health and Human Services in consultation with the Secretary of the Treasury and the Secretary of Labor.

Accrual Balance at Time of Leave (initial all lines)

____ I understand that if this leave qualifies as FMLA, other requirements may be applicable, pursuant to the FMLA policy 4.04 in the Employee Policy Manual or based on modifications made to FMLA by FFCRA.

____ I understand that in the event all accrued time for sick, vacation, designated holiday and compensatory time are exhausted, I will continue to use sick time, resulting in a negative accrual balance and that any negative sick accrual time must be repaid to the City.

____ I agree that this executed affidavit will serve as approval for leave through the end date below and that it is my responsibility to either return to work or submit a separate affidavit by this end date.

End Date: _____

____ I certify that as of today, I have the following hours accrued with the City and accrued hours will be deducted in the order outlined below:



Rank	Type	Accrued Amount
_____	Sick	_____
_____	Vacation	_____
_____	Designated Holiday	_____
_____	Compensatory	_____

Affidavit

I hereby attest and/or affirm that the aforementioned information is accurate and true to the best of my ability. I acknowledge that any dishonest and/or untruthful statements can result in penalty disciplinary action, including but not limited to reprimand and/or termination. I agree to all provisions of policy HR130. I will reimburse the City for any negative accrued sick time through future accruals, payroll deduction or direct payment to the City. I understand that upon separation from employment with the City, any negative sick accrual balance resulting from this agreement will be paid back to the City through my final paycheck and, if necessary, separate payment. I have been notified that the funds associated with payments of my related salary and/or benefits may be subject to federally regulated public assistance programs, further making me subject to potential federal penalties provided in Title 18 U.S.C. Chapter 47.

Employee Name (Printed): _____

Department: _____

Job Title: _____

Employee Signature

Date

SUPERVISOR ACTION

Supervisor Name (Printed): _____

Supervisor Signature

Date