

Certification of Health Care Provider¹
(Supplemental Paid Sick Leave)



Employee Name: _____ ID#: _____ Phone: _____

The individual named above has requested leave under the Supplemental Paid Sick Leave provision of the California Senate Bill 114. As this individual's employer, we request health care provider documentation in order to determine the employee's eligibility for such leave. Please answer the questions below and return this form to your patient.

Provider's Name: _____

Address: _____

Telephone: _____ Fax: _____

Complete this section if the individual named above is your patient. (check only one box)

I have advised the individual named above to self-quarantine or isolated due to COVID-19 related reasons.

The individual named above is experiencing COVID-19 symptoms and is waiting diagnosis

Duration of time the employee will be unable to work related to this event: _____
From To

Complete this section if the individual named above is caring for your patient. (check only one box)

Name of family patient: _____ DOB: _____

Relationship to individual named above: _____

I have advised the patient to self-quarantine or isolated due to COVID-19 related reasons.

The patient is experiencing COVID-19 symptom and is waiting diagnosis.

Duration of time the patient will need care by the employee named above: _____
From To

Health Care Provider Signature Date

¹ If other health care provider documentation is already available, please attach it, and the employee should complete as much as possible of the information indicated above