

Pacific Maritime Association

Dockworker Self-Service Portal

Leave Request

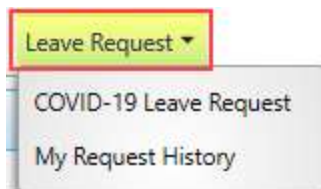
User Guide

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Leave Request

Paid sick leave or paid family and medical leave requests are submitted here.



COVID-19 Leave Request

Go to **Leave Request** > then click on **COVID19 Leave Request**.



Select a reason for your leave request, complete all the fields marked with an asterisk and upload supporting documentation when required.

Complete the following request if you are applying for paid sick leave or paid family and medical leave. All fields marked with an asterisk are required. You may only ask for leave if you are unable to work for one of the listed reasons.

	Leave Reason
<input checked="" type="radio"/>	1. You tested positive for COVID-19 and are providing supporting documentation.
<input type="radio"/>	2. You are/were quarantined due to COVID-19 - this means being quarantined or advised by a healthcare provider to self-quarantine due to concerns that you have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	3. You are/were caring for a family member with COVID-19 - this means caring for a family member with COVID-19, or who is particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	4. You are/were experiencing symptoms of COVID-19 and are seeking a healthcare provider's certificate.
<input type="radio"/>	5. You are/were caring for someone quarantined due to diagnosis of COVID-19 - this means caring for someone quarantined due to a diagnosis of COVID-19, or someone who was advised by a healthcare provider to self-quarantine due to concerns that they have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19.
<input type="radio"/>	6. You are/were caring for a child whose school or place of care is closed for COVID-19.

Leave request(s) can be viewed on [My Request History](#) page.

[Home](#) > [Leave Request](#) > [My Request History](#)

Request Type	Start Date	Period	Unit	Status	Remarks	Additional information		
						Provider	Dependent Name	Facility Closure Until
COVID-19 Paid Sick Leave	06/15/2020	10	Days	Requested		Doctor's name		

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>
15

You tested positive for COVID-19

1. You tested positive for COVID-19 and are providing supporting documentation.

Select leave start date from the drop-down calendar, then the number of days (10 days max) you are requesting.

Apply For Emergency Paid Sick Leave

Leave Start Date (mm/dd/yyyy)*

of Days Requested (Max Eligibility is 10) *

June 2020

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Apply For Emergency Paid Sick Leave

Leave Start Date (mm/dd/yyyy)*

of Days Requested (Max Eligibility is 10) *

- Enter the name of the healthcare provider that diagnosed you with COVID-19.
- Select Yes or No, if you applied for, or are receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave.
- Upload supporting documentation.

Additional Info

Name of the healthcare provider that diagnosed you with COVID-19 *


Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: * ☐ Yes ☒ No

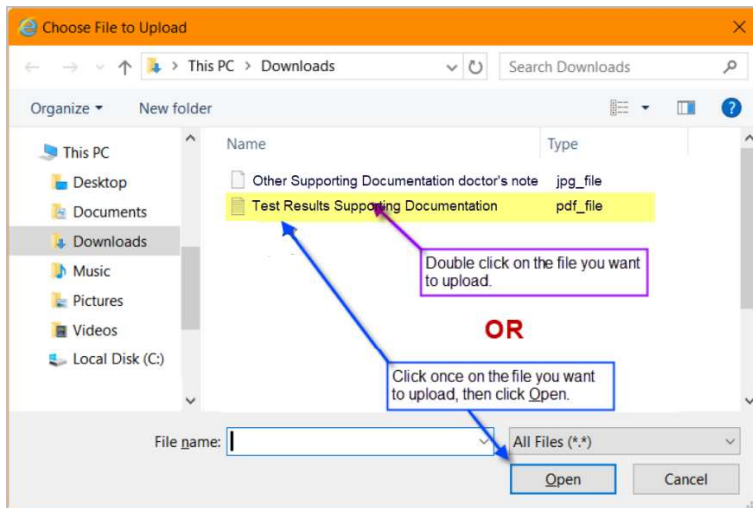
Upload* jpg,doc,docx,pdf


Note: Documentation requested will not be used to deny benefits under FFCRA if FFCRA would not permit use of such documents.

Select *Test Result* or *Other Supporting Documentation* from the Upload picklist, then click to upload the supporting documentation.




This will open up the 'File Manager / Explorer'.  Locate the file you are submitting for supporting documentation. Double click on the file you want to upload, or click once to select the file, then click **Open** at the bottom right corner.




The filename you selected will display below the  button if the upload is successful.

If leave request is submitted without supporting documentation, an error message will

display.  **Please select Document for upload.**

You must read, accept and check the Certification checkbox before submitting your leave request.

☒
Certification. I certify that I am submitting this request because I am unable to work for the reasons stated above and for the time period requested. I understand that providing complete, sufficient and timely information is required to obtain or retain the benefit of any paid leave, and that my submission of this request does not guarantee that I am eligible for or may receive any paid leave. I agree that the information provided in connection with my request for paid leave is truthful and accurate to the best of my knowledge. *

An error message will appear if you create a leave request without checking the certification checkbox.  **Please accept the certification by checking the checkbox below.**

Complete the following request if you are applying for paid sick leave or paid family and medical leave. All fields marked with an asterisk are required. You may only ask for leave if you are unable to work for one of the listed reasons.

Leave Reason	
<input checked="" type="radio"/>	1. You tested positive for COVID-19 and are providing supporting documentation.
<input type="radio"/>	2. You are/were quarantined due to COVID-19 - this means being quarantined or advised by a healthcare provider to self-quarantine due to concerns that you have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	3. You are/were caring for a family member with COVID-19 - this means caring for a family member with COVID-19, or who is particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	4. You are/were experiencing symptoms of COVID-19 and are seeking a healthcare provider's certificate.
<input type="radio"/>	5. You are/were caring for someone quarantined due to diagnosis of COVID-19 - this means caring for someone quarantined due to a diagnosis of COVID-19, or someone who was advised by a healthcare provider to self-quarantine due to concerns that they have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19.
<input type="radio"/>	6. You are/were caring for a child whose school or place of care is closed for COVID-19.

Apply For Emergency Paid Sick Leave	Apply For Expanded Family and Medical Leave
Leave Start Date (mm/dd/yyyy)* <input type="text" value="06/15/2020"/> # of Days Requested (Max Eligibility is 10) * <input type="text" value="10 Days"/>	Leave Start Date (mm/dd/yyyy)* <input type="text" value="mm/dd/yyyy"/> # of Weeks Requested (Max Eligibility is 12) * <input type="text" value="12 Weeks"/>

Additional Info

Name of the healthcare provider that diagnosed you with COVID-19 *

Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: * ☐ Yes ☒ No

Upload*

File successfully uploaded

Note: Documentation requested will not be used to deny benefits under FFCRA if FFCRA would not permit use of such documents.

☒ **Certification.** I certify that I am submitting this request because I am unable to work for the reasons stated above and for the time period requested. I understand that providing complete, sufficient and timely information is required to obtain or retain the benefit of any paid leave, and that my submission of this request does not guarantee that I am eligible for or may receive any paid leave. I agree that the information provided in connection with my request for paid leave is truthful and accurate to the best of my knowledge. *

Click **Submit** to create your leave request.

Message will display at the top indicating that leave request was successfully submitted.

 **Leave Request Submitted Successfully.**

Go to **Leave Request** > then click on **My Request History** to view your leave request.

You are/were quarantined due to COVID-19

- this means being quarantined or advised by a healthcare provider to self-quarantine due to concerns that you have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19, and are providing supporting documentation.



2. You are/were quarantined due to COVID-19 - this means being quarantined or advised by a healthcare provider to self-quarantine due to concerns that you have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19, and are providing supporting documentation.

Select leave start date from the drop-down calendar, then the number of days (10 days max) you are requesting.

Apply For Emergency Paid Sick Leave

Leave Start Date (mm/dd/yyyy)* 06/15/2020

of Days Requested (Max Eligibility is 10) *

June 2020

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

Apply For Emergency Paid Sick Leave

Leave Start Date (mm/dd/yyyy)* 06/15/2020

of Days Requested (Max Eligibility is 10) * 10 Days

- Enter the name of the governmental authority that issued the quarantine or isolation order.
- Select Yes or No, if you applied for, or are receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave.
- Upload supporting documentation.

Additional Info

Name of the governmental authority that issued the quarantine or isolation order *

Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: * ☐ Yes ☒ No

Upload* Quarantine Order Choose jpg,doc,docx,pdf

Note: Documentation requested will not be used to deny benefits under FFCRA if FFCRA would not permit use of such documents.


Select *Quarantine Order* or *Other Supporting Documentation* from the Upload picklist, then click Choose to upload the supporting documentation.

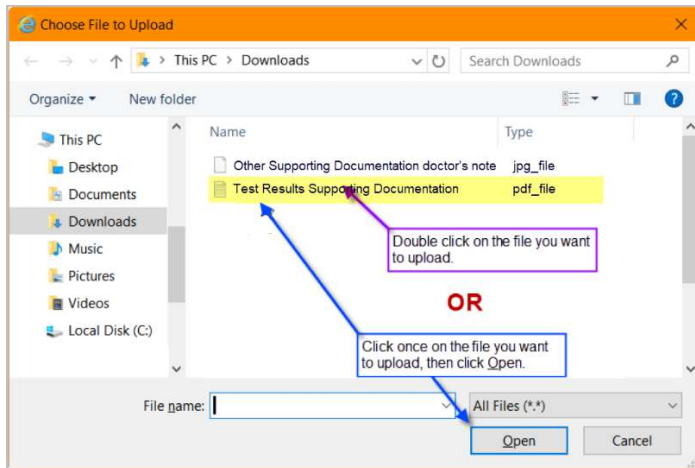
Upload* Quarantine Order Choose jpg,doc,docx,pdf


Quarantine Order

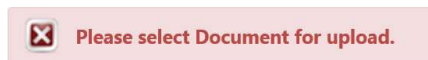
Other Supporting Documentation

Click **Choose** to upload file

This will open up the 'File Manager / Explorer'.  Locate the file you are submitting for supporting documentation. Double click on the file you want to upload, or click once to select the file, then click the **Open** at the bottom right corner.



The filename you selected will display below the  button if the upload is successful. If leave request is submitted without supporting documentation, an error message will display.



You must read, accept and check the Certification checkbox before submitting your leave request.

☒ **Certification.** I certify that I am submitting this request because I am unable to work for the reasons stated above and for the time period requested. I understand that providing complete, sufficient and timely information is required to obtain or retain the benefit of any paid leave, and that my submission of this request does not guarantee that I am eligible for or may receive any paid leave. I agree that the information provided in connection with my request for paid leave is truthful and accurate to the best of my knowledge. *

An error message will appear if you create a leave request without checking the certification checkbox.



Complete the following request if you are applying for paid sick leave or paid family and medical leave. All fields marked with an asterisk are required. You may only ask for leave if you are unable to work for one of the listed reasons.

Leave Reason	
<input type="radio"/>	1. You tested positive for COVID-19 and are providing supporting documentation.
<input checked="" type="radio"/>	2. You are/were quarantined due to COVID-19 - this means being quarantined or advised by a healthcare provider to self-quarantine due to concerns that you have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	3. You are/were caring for a family member with COVID-19 - this means caring for a family member with COVID-19, or who is particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	4. You are/were experiencing symptoms of COVID-19 and are seeking a healthcare provider's certificate.
<input type="radio"/>	5. You are/were caring for someone quarantined due to diagnosis of COVID-19 - this means caring for someone quarantined due to a diagnosis of COVID-19, or someone who was advised by a healthcare provider to self-quarantine due to concerns that they have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19.
<input type="radio"/>	6. You are/were caring for a child whose school or place of care is closed for COVID-19.

Apply For Emergency Paid Sick Leave	Apply For Expanded Family and Medical Leave
Leave Start Date (mm/dd/yyyy)* 06/15/2020	Leave Start Date (mm/dd/yyyy)* mm/dd/yyyy
# of Days Requested (Max Eligibility is 10) * 10 Days	# of Weeks Requested (Max Eligibility is 12) * 12 Weeks

Additional Info

Name of the governmental authority that issued the quarantine or isolation order *
Enter gov authority here

Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave? *
☐ Yes ☒ No

Upload*
Quarantine Order

+ Choose
COVID-19 Documentation.pdf

File successfully uploaded

Note: Documentation requested will not be used to deny benefits under FFCRA if FFCRA would not permit use of such documents.

☒ **Certification.** I certify that I am submitting this request because I am unable to work for the reasons stated above and for the time period requested. I understand that providing complete, sufficient and timely information is required to obtain or retain the benefit of any paid leave, and that my submission of this request does not guarantee that I am eligible for or may receive any paid leave. I agree that the information provided in connection with my request for paid leave is truthful and accurate to the best of my knowledge. *

Click to create leave request **Submit**

Click **Submit** to create your leave request.

Message will display at the top indicating that leave request was successfully submitted.



Go to **Leave Request** > then click on **My Request History** to view your leave request.

You are/were caring for a family member with COVID-19

- this means caring for a family member with COVID-19, or who is particularly vulnerable to COVID-19, and are providing supporting documentation.

3. You are/were caring for a family member with COVID-19 - this means caring for a family member with COVID-19, or who is particularly vulnerable to COVID-19, and are providing supporting documentation.

Select leave start date from the drop-down calendar, then the number of days (10 days max) you are requesting.

Apply For Emergency Paid Sick Leave

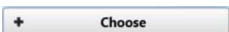
Leave Start Date (mm/dd/yyyy)* 06/15/2020

of Days Requested (Max Eligibility is 10) * 10 Days

- Enter the name of the individual for whom you are caring for.
- Select your relationship to the individual for whom you are caring from the picklist.

Spouse

Spouse
Domestic Partner
Parent
Child
Other


- Select Yes or No, if you applied for, or are receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave.
- Upload supporting documentation. Click  to upload the supporting documentation.

Additional Info


Name of the individual for whom you are caring *

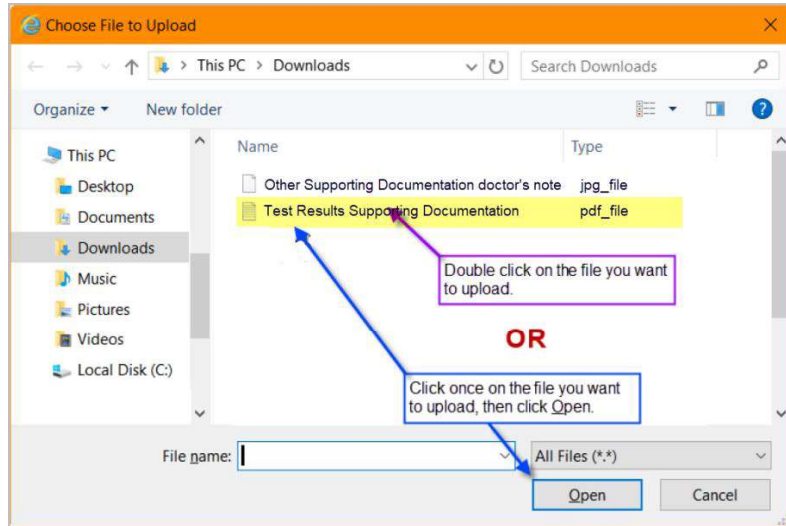
Your relationship to the individual for whom you are caring * Spouse

Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: * ☐ Yes ☒ No

Upload* Supporting Documentation  Choose .jpg,.doc,.docx,.pdf

Note: Documentation requested will not be used to deny benefits under FFCRA if FFCRA would not permit use of such documents.


This will open up the 'File Manager / Explorer'.  Locate the file you are submitting for supporting documentation. Double click on the file you want to upload, or click once to select the file, then click the **Open** at the bottom right corner.



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Complete the following request if you are applying for paid sick leave or paid family and medical leave. All fields marked with an asterisk are required. You may only ask for leave if you are unable to work for one of the listed reasons.

Leave Reason	
<input type="radio"/>	1. You tested positive for COVID-19 and are providing supporting documentation.
<input type="radio"/>	2. You are/were quarantined due to COVID-19 - this means being quarantined or advised by a healthcare provider to self-quarantine due to concerns that you have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19, and are providing supporting documentation.
<input checked="" type="radio"/>	3. You are/were caring for a family member with COVID-19 - this means caring for a family member with COVID-19, or who is particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	4. You are/were experiencing symptoms of COVID-19 and are seeking a healthcare provider's certificate.
<input type="radio"/>	5. You are/were caring for someone quarantined due to diagnosis of COVID-19 - this means caring for someone quarantined due to a diagnosis of COVID-19, or someone who was advised by a healthcare provider to self-quarantine due to concerns that they have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19.
<input type="radio"/>	6. You are/were caring for a child whose school or place of care is closed for COVID-19.

Apply For Emergency Paid Sick Leave	Apply For Expanded Family and Medical Leave
Leave Start Date (mm/dd/yyyy)* <input type="text" value="06/15/2020"/>	Leave Start Date (mm/dd/yyyy)* <input type="text" value="mm/dd/yyyy"/>
# of Days Requested (Max Eligibility is 10) * <input type="text" value="10 Days"/>	# of Weeks Requested (Max Eligibility is 12) * <input type="text" value="12 Weeks"/>

Additional Info

Name of the individual for whom you are caring *

Your relationship to the individual for whom you are caring *

Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: * ☐ Yes ☒ No

Upload*

Choose

Note: Documentation requested will not be used to deny benefits under FFCRA if FFCRA would not permit use of such documents.

☒ **Certification.** I certify that I am submitting this request because I am unable to work for the reasons stated above and for the time period requested. I understand that providing complete, sufficient and timely information is required to obtain or retain the benefit of any paid leave, and that my submission of this request does not guarantee that I am eligible for or may receive any paid leave. I agree that the information provided in connection with my request for paid leave is truthful and accurate to the best of my knowledge. *

Click **Submit** to create your leave request.

Message will display at the top indicating that leave request was successfully submitted.

 **Leave Request Submitted Successfully.**

Go to **Leave Request** > then click on **My Request History** to view your leave request.

You are/were experiencing symptoms of COVID-19



4. You are/were experiencing symptoms of COVID-19 and are seeking a healthcare provider's certificate.

Select leave start date from the drop-down calendar, then the number of days (10 days max) you are requesting.

Apply For Emergency Paid Sick Leave

Leave Start Date (mm/dd/yyyy)* 06/15/2020

of Days Requested (Max Eligibility is 10) * 10 Days

- Enter the name of the healthcare provider that you are consulting to obtain a medical diagnosis.
- Select Yes or No, if you applied for, or are receiving weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave.
- Upload supporting documentation.

Additional Info

Name of the healthcare provider that you are consulting to obtain a medical diagnosis * Healthcare provider's name

Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: * ☐ Yes ☒ No Click **Choose** to upload file

Upload Test Result + **Choose** jpg.doc.docx.pdf


Note: Documentation requested will not be used to deny benefits under FFCRA if FFCRA would not permit use of such documents.

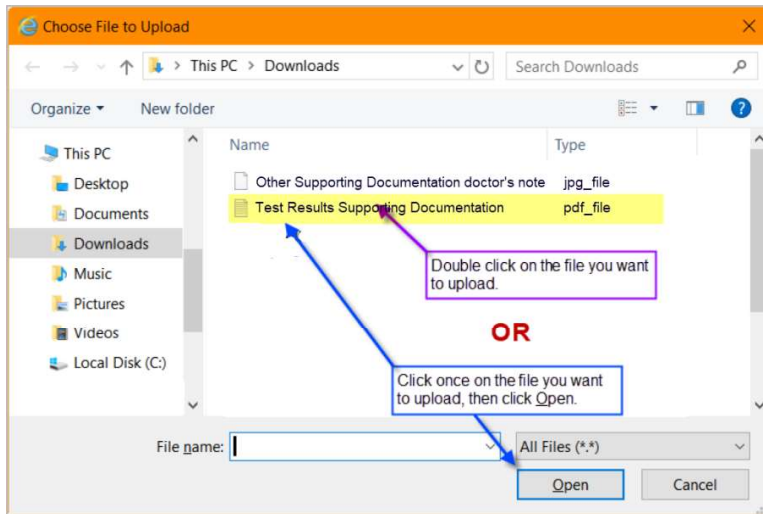
Select *Test Result*, *Healthcare Provider's Certificate* or *Other Supporting Documentation* from the Upload picklist, then click + **Choose** to upload the supporting documentation.


Upload Test Result + **Choose** jpg.doc.docx.pdf

1 2

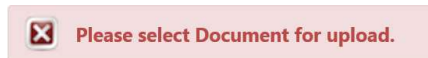
Click **Choose** to upload file

This will open up the 'File Manager / Explorer'.  Locate the file you are submitting for supporting documentation. Double click on the file you want to upload, or click once to select the file, then click the **Open** at the bottom right corner.



The filename you selected will display below the  button if the upload is successful.

If leave request is submitted without supporting documentation, an error message will display.




Click the checkbox to confirm that you have applied for California Paid Family Leave or Unemployment Insurance benefits in the state where you qualify.

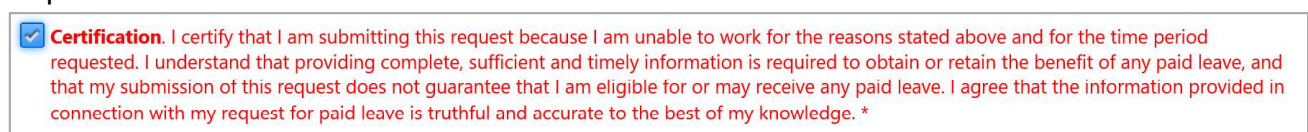


An error message will appear if you create a leave request without checking the confirmation checkbox.



Click the  icon for information on how to file Unemployment Insurance.

You must read, accept and check the Certification checkbox before submitting your leave request.



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Complete the following request if you are applying for paid sick leave or paid family and medical leave. All fields marked with an asterisk are required. You may only ask for leave if you are unable to work for one of the listed reasons.

Leave Reason	
<input type="radio"/>	1. You tested positive for COVID-19 and are providing supporting documentation.
<input type="radio"/>	2. You are/were quarantined due to COVID-19 - this means being quarantined or advised by a healthcare provider to self-quarantine due to concerns that you have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	3. You are/were caring for a family member with COVID-19 - this means caring for a family member with COVID-19, or who is particularly vulnerable to COVID-19, and are providing supporting documentation.
<input checked="" type="radio"/>	4. You are/were experiencing symptoms of COVID-19 and are seeking a healthcare provider's certificate.
<input type="radio"/>	5. You are/were caring for someone quarantined due to diagnosis of COVID-19 - this means caring for someone quarantined due to a diagnosis of COVID-19, or someone who was advised by a healthcare provider to self-quarantine due to concerns that they have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19.
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Apply For Emergency Paid Sick Leave	Apply For Expanded Family and Medical Leave
Leave Start Date (mm/dd/yyyy)* 06/15/2020	Leave Start Date (mm/dd/yyyy)* mm/dd/yyyy
# of Days Requested (Max Eligibility is 10) * 10 Days	# of Weeks Requested (Max Eligibility is 12) * 12 Weeks

Additional Info

Name of the healthcare provider that you are consulting to obtain a medical diagnosis *
Healthcare provider's name

Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: *
☐ Yes ☒ No

Upload
Test Result

+ Choose
COVID-19 Supporting Documentation.pdf

File successfully uploaded

Note: Documentation requested will not be used to deny benefits under FFCRA if FFCRA would not permit use of such documents.

☒ I have applied for California Paid Family Leave (PFL) or Unemployment Insurance (UI) benefits in the state for where I qualify. * ⓘ

☒ **Certification.** I certify that I am submitting this request because I am unable to work for the reasons stated above and for the time period requested. I understand that providing complete, sufficient and timely information is required to obtain or retain the benefit of any paid leave, and that my submission of this request does not guarantee that I am eligible for or may receive any paid leave. I agree that the information provided in connection with my request for paid leave is truthful and accurate to the best of my knowledge. *

Click to create leave request **Submit**

Click **Submit** to create your leave request.

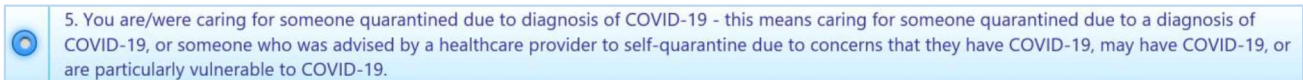
Message will display at the top indicating that leave request was successfully submitted.

i Leave Request Submitted Successfully.

Go to **Leave Request** > then click on **My Request History** to view your leave request.

You are/were caring for someone quarantined due to diagnosis of COVID-19

- this means caring for someone quarantined due to a diagnosis of COVID-19, or someone who was advised by a healthcare provider to self-quarantine due to concerns that they have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19.



Select leave start date from the drop-down calendar, then the number of days (10 days max) you are requesting.

The screenshot shows two overlapping forms titled "Apply For Emergency Paid Sick Leave". The top form has a "Leave Start Date (mm/dd/yyyy)*" field with "06/15/2020" entered. Below it is a calendar for "June 2020" with the 15th selected. The bottom form also has the "Leave Start Date" field with "06/15/2020" and a "# of Days Requested (Max Eligibility is 10) *" field with a dropdown menu set to "10 Days".

- Enter the individual's name for whom you are caring.
- Select from the picklist menu, your relationship to the individual for whom you are caring.

A screenshot of a picklist menu. The top dropdown shows "Spouse". Below it, a list of options is displayed: "Spouse", "Domestic Partner", "Parent", "Child", and "Other". The "Spouse" option is currently selected and highlighted.

- Enter the name of the governmental authority that issued the quarantine or isolation order, or the name of the healthcare provider.
- Select Yes or No, if you applied for, or are receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave.

Additional Info

Provide the individual's name *

Your relationship to the individual for whom you are caring *

Spouse

Name of the governmental authority that issued the quarantine or isolation order, or the name of the healthcare provider *

Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: *


☐ Yes
☒ No

Click the checkbox to confirm that you have applied for California Paid Family Leave or Unemployment Insurance benefits in the state where you qualify.

☒ I have applied for California Paid Family Leave (PFL) or Unemployment Insurance (UI) benefits in the state for where I qualify. * 

An error message will appear if you create a leave request without checking the confirmation checkbox.


 Please confirm that you have applied for California Paid Family Leave or UI from your state by clicking the check box below.

Click the  icon for information on how to file Unemployment Insurance.

You must read, accept and check the Certification checkbox before submitting your leave request.

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An error message will appear if you create a leave request without checking the certification checkbox.

 Please accept the certification by checking the checkbox below.

Complete the following request if you are applying for paid sick leave or paid family and medical leave. All fields marked with an asterisk are required. You may only ask for leave if you are unable to work for one of the listed reasons.

Leave Reason	
<input type="radio"/>	1. You tested positive for COVID-19 and are providing supporting documentation.
<input type="radio"/>	2. You are/were quarantined due to COVID-19 - this means being quarantined or advised by a healthcare provider to self-quarantine due to concerns that you have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	3. You are/were caring for a family member with COVID-19 - this means caring for a family member with COVID-19, or who is particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	4. You are/were experiencing symptoms of COVID-19 and are seeking a healthcare provider's certificate.
<input checked="" type="radio"/>	5. You are/were caring for someone quarantined due to diagnosis of COVID-19 - this means caring for someone quarantined due to a diagnosis of COVID-19, or someone who was advised by a healthcare provider to self-quarantine due to concerns that they have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19.
<input type="radio"/>	6. You are/were caring for a child whose school or place of care is closed for COVID-19.

Apply For Emergency Paid Sick Leave		Apply For Expanded Family and Medical Leave	
Leave Start Date (mm/dd/yyyy)*	<input type="text" value="06/15/2020"/>	Leave Start Date (mm/dd/yyyy)*	<input type="text" value="mm/dd/yyyy"/>
# of Days Requested (Max Eligibility is 10) *	<input type="text" value="10 Days"/>	# of Weeks Requested (Max Eligibility is 12) *	<input type="text" value="12 Weeks"/>

Additional Info

Provide the individual's name *

Your relationship to the individual for whom you are caring *

Name of the governmental authority that issued the quarantine or isolation order, or the name of the healthcare provider *

Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: *

☐ Yes ☒ No

☒ I have applied for California Paid Family Leave (PFL) or Unemployment Insurance (UI) benefits in the state for where I qualify. * [i](#)

☒ **Certification.** I certify that I am submitting this request because I am unable to work for the reasons stated above and for the time period requested. I understand that providing complete, sufficient and timely information is required to obtain or retain the benefit of any paid leave, and that my submission of this request does not guarantee that I am eligible for or may receive any paid leave. I agree that the information provided in connection with my request for paid leave is truthful and accurate to the best of my knowledge. *

[Click to create leave request](#)

Click **Submit** to create your leave request.

Message will display at the top indicating that leave request was successfully submitted.

 **Leave Request Submitted Successfully.**

Go to **Leave Request** > then click on **My Request History** to view your leave request.

You are/were caring for a child whose school or place of care is closed for COVID-19



6. You are/were caring for a child whose school or place of care is closed for COVID-19.

Select leave start date from the drop-down calendar, then the number of days (10 days max) you are requesting.

Apply For Emergency Paid Sick Leave
 Leave Start Date (mm/dd/yyyy)* 06/15/2020
 # of Days Requested (Max Eligibility is 10) *

June 2020

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

Apply For Emergency Paid Sick Leave
 Leave Start Date (mm/dd/yyyy)* 06/15/2020
 # of Days Requested (Max Eligibility is 10) * 10 Days

If you are also applying for Family and Medical Leave, select the date from *Apply for Expanded Family and Medical Leave*. The maximum is 12 weeks.

☒ **Apply For Expanded Family and Medical Leave**
 Leave Start Date (mm/dd/yyyy)* 06/15/2020
 # of Weeks Requested (Max Eligibility is 12) *

June 2020

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

☒ **Apply For Expanded Family and Medical Leave**
 Leave Start Date (mm/dd/yyyy)* 06/15/2020
 # of Weeks Requested (Max Eligibility is 12) * 12 Weeks

If you are only applying for Sick Leave, uncheck Apply For Expanded Family and Medical Leave.

☒ **Apply For Emergency Paid Sick Leave**
 Leave Start Date (mm/dd/yyyy)* 06/15/2020
 # of Days Requested (Max Eligibility is 10) * 10 Days

☐ **Apply For Expanded Family and Medical Leave**
 Leave Start Date (mm/dd/yyyy)* mm/dd/yyyy
 # of Weeks Requested (Max Eligibility is 12) * 12 Weeks

- Enter the child's last and first name.
- Select child's age from the picklist menu.
- Enter the school, day care facility or childcare provider's name. (30 characters max)
- Enter the last date the school/childcare is closed. (Date format mm/dd/yyyy)
- Select Yes or No, confirming that you are unable to work because special circumstances exist requiring you to provide care.

➤ Select Yes or No, if you applied for, or are receiving weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave.

Additional Info	
Child Name (Last, First) *	<input type="text"/>
Child Age *	<input type="text" value="6 Years"/>
Name of the school or day care facility, or childcare provider, that is closed or unavailable *	<input type="text"/>
Until what date is the school/childcare closed? *	<input type="text" value="mm/dd/yyyy"/>
For a child who is 14 years of age or older, you confirm that you are unable to work because special circumstances exist requiring you to provide care.	<input type="radio"/> Yes <input checked="" type="radio"/> No
Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: *	<input type="radio"/> Yes <input checked="" type="radio"/> No

Verify that no other person will be providing care for the child during the period for which is requested for family and medical leave by clicking the checkbox ☒.

<input type="checkbox"/> In seeking leave for this reason, I represent that no other person will be providing care for the child during the period for which I will be receiving family and medical leave. *
--

Click the checkbox to confirm that you have applied for California Paid Family Leave or Unemployment Insurance benefits in the state where you qualify.

<input checked="" type="checkbox"/> I have applied for California Paid Family Leave (PFL) or Unemployment Insurance (UI) benefits in the state for where I qualify. * 

An error message will appear if you create a leave request without checking the confirmation checkbox.

 Please confirm that you have applied for California Paid Family Leave or UI from your state by clicking the check box below.
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Click the  icon for information on how to file Unemployment Insurance.

You must read, accept and check the Certification checkbox before submitting your leave request.

<input checked="" type="checkbox"/> Certification. I certify that I am submitting this request because I am unable to work for the reasons stated above and for the time period requested. I understand that providing complete, sufficient and timely information is required to obtain or retain the benefit of any paid leave, and that my submission of this request does not guarantee that I am eligible for or may receive any paid leave. I agree that the information provided in connection with my request for paid leave is truthful and accurate to the best of my knowledge. *

An error message will appear if you create a leave request without checking the certification checkbox.

 Please accept the certification by checking the checkbox below.

Complete the following request if you are applying for paid sick leave or paid family and medical leave. All fields marked with an asterisk are required. You may only ask for leave if you are unable to work for one of the listed reasons.

Leave Reason	
<input type="radio"/>	1. You tested positive for COVID-19 and are providing supporting documentation.
<input type="radio"/>	2. You are/were quarantined due to COVID-19 - this means being quarantined or advised by a healthcare provider to self-quarantine due to concerns that you have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	3. You are/were caring for a family member with COVID-19 - this means caring for a family member with COVID-19, or who is particularly vulnerable to COVID-19, and are providing supporting documentation.
<input type="radio"/>	4. You are/were experiencing symptoms of COVID-19 and are seeking a healthcare provider's certificate.
<input type="radio"/>	5. You are/were caring for someone quarantined due to diagnosis of COVID-19 - this means caring for someone quarantined due to a diagnosis of COVID-19, or someone who was advised by a healthcare provider to self-quarantine due to concerns that they have COVID-19, may have COVID-19, or are particularly vulnerable to COVID-19.
<input checked="" type="radio"/>	6. You are/were caring for a child whose school or place of care is closed for COVID-19.

<input checked="" type="checkbox"/> Apply For Emergency Paid Sick Leave Leave Start Date (mm/dd/yyyy)* <input type="text" value="05/01/2020"/> # of Days Requested (Max Eligibility is 10) * <input type="text" value="10 Days"/>	<input checked="" type="checkbox"/> Apply For Expanded Family and Medical Leave Leave Start Date (mm/dd/yyyy)* <input type="text" value="05/10/2020"/> # of Weeks Requested (Max Eligibility is 12) * <input type="text" value="12 Weeks"/>
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Additional Info

Child Name (Last, First) *	<input type="text" value="Child's last and first name"/>
Child Age *	<input type="text" value="7 Years"/>
Name of the school or day care facility, or childcare provider, that is closed or unavailable *	<input type="text" value="School, day care or childcare"/>
Until what date is the school/childcare closed? *	<input type="text" value="08/18/2020"/>
For a child who is 14 years of age or older, you confirm that you are unable to work because special circumstances exist requiring you to provide care.	<input type="radio"/> Yes <input checked="" type="radio"/> No
Have you applied for, or are you receiving, weekly indemnity benefits under the ILWU-PMA Welfare Plan or any other sick pay benefit for the same time period for which you are now seeking paid leave?: *	<input type="radio"/> Yes <input checked="" type="radio"/> No


☒ In seeking leave for this reason, I represent that no other person will be providing care for the child during the period for which I will be receiving family and medical leave. *

☒ I have applied for California Paid Family Leave (PFL) or Unemployment Insurance (UI) benefits in the state for where I qualify. * ⓘ

☒ **Certification.** I certify that I am submitting this request because I am unable to work for the reasons stated above and for the time period requested. I understand that providing complete, sufficient and timely information is required to obtain or retain the benefit of any paid leave, and that my submission of this request does not guarantee that I am eligible for or may receive any paid leave. I agree that the information provided in connection with my request for paid leave is truthful and accurate to the best of my knowledge. *

Click **Submit** to create your leave request.

Message will display at the top indicating that leave request was successfully submitted.

 **Leave Request Submitted Successfully.**

Go to **Leave Request** > then click on **My Request History** to view your leave request.

My Request History

Leave request and status can be found on **My Request History** page.

Go to **Leave Request** > then click **My Request History**.



Payroll ▾ Reports/Docs ▾ Leave Request ▾ Setup ▾ ? Help

🏠 ▸ Leave Request ▸ My Request History

Request Type ▾	Start Date ▾	Period ▾	Unit	Status	Remarks ▾	Additional information		
						Provider	Dependent Name	Facility Closure Until
COVID-19 Paid Sick Leave	06/05/2020	10	Days	Requested		Doctor's name		

< 1 15 ▾

Requested Date ▾	Status ▾	Notes	Week Paid
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< 1 15 ▾

No records found.

Leave request(s) can be sorted by *Request Type*, *Start Date*, *Period* and *Remark*. Click on

the  icon to sort.

🏠 ▸ Leave Request ▸ <u>My Request History</u>								
Request Type ▾	Start Date ▾	Period ▾	Unit	Status	Remarks ▾	Additional information		
						Provider	Dependent Name	Facility Closure Until
COVID-19 Paid Sick Leave	05/04/2020	2	Days	Under Review		Dr. Smith		
COVID-19 Paid Sick Leave	05/06/2020	3	Days	Requested		Dr. Martin		
COVID-19 Paid Sick Leave	05/10/2020	3	Days	Requested	Please provide more information related to child's special needs.	Best Day Care1	xyz, abc	06/30/2020
COVID-19 Paid Sick Leave	05/11/2020	3	Days	Denied	Dependent is 14 or above, but special needs checkbox is not selected. please acknowledge if he/she has any special needs and re-submit request.	Best Daycare Facility	xyz, abc	06/30/2020
COVID-19 Paid Family Leave	06/01/2020	3	Weeks	Requested		day care 1	xyz, abc	06/30/2020
COVID-19 Paid Sick Leave	06/10/2020	1	Days	Under Review		Authority 1		

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19 5

You tested positive for COVID-19 2