Department of Children of Families

Request for COVID Related Temporary Telework

Name: ____ **Office/Division/Bureau:**_____________________________________

Title: ____ **Function:** ____

Name and Title of Supervisor: ____

Reason for Request:

☐ Returning from a CDC designated Level 3 Country	☐ Contact with a person who had contact with a person directed to self-monitor by a medical provider or government official (name and title):
☐ Returning for a CDC designated Level 2 Country	
☐ Caring for sick family with COVID	
☐Transportation disruptions	☐ Directed by a medical provider or government official to self-monitor (name and title):
☐ Medically compromised condition on record	
☐ Concerns about exposure in public settings	☐ Domicile with or had contact with a person directed to self-monitor by a medical provider or government official (name and title):
☐ Care of a Parent	
☐ Child Care (number and age of child(ren)	

Work to be performed:

Supervisor recommendation: ____Yes _____No

Reason if not recommending approval :

Supervisory Signature: ____ Date:_______________________

Program Supervisor recommendation (if applicable): ______Yes ______ No

Reason if not recommending approval:

Supervisory Signature: ____ Date:_______________________

Director Approval _____Yes _____ No

Reason if not recommending approval:

Supervisory Signature: ____ Date:_______________________