



SECTION: HUMAN RESOURCES	REFERENCE NUMBER: A24
SUBJECT: QUARANTINE LEAVE FOR PEACE OFFICERS, FIREFIGHTERS AND EMERGENCY MEDICAL TECHNICIANS	EFFECTIVE DATE: 09/01/2021
FROM: CRYSTAL CALDERA, CITY MANAGER	LAST REVISION DATE: 1/09/2023

A. PURPOSE

It is the goal of the City of Leon Valley to develop and adopt a policy allowing the use of paid quarantine leave pursuant to Texas Local Government Code Section 180.008. The City of Leon Valley hereby adopts a paid quarantine leave policy for firefighters, peace officers, and emergency medical technicians who are employed by, appointed by, or elected to the city and ordered to quarantine or isolate due to possible or known exposure to a communicable disease while on duty. (Ref. Tex. Loc. Gov't Code 180.008(b).)

B. DEFINITIONS

1. Emergency Medical Technician- Individual who is employed by the city and certified as an emergency medical technician under Chapter 773, Health and Safety code.
2. Firefighter- Paid employee of the city's fire department who:
 - a. holds a position that requires substantial knowledge of firefighting,
 - b. has met the requirements for certification by the Texas Commission on Fire Protection under Chapter 419, Government Code, and
 - c. performs at least one of the following functions:
 - fire suppression, fire prevention, fire training, fire safety education, fire maintenance, fire communications, fire medical emergency technology, fire photography, fire administration; or fire arson investigations.
3. Paid Quarantine Leave- All employment benefits and compensation, including leave accrual, pension and health plan benefits provided by the city; and if applicable, reimbursement for reasonable costs related to the quarantine, including lodging, medical, food and transportation costs up to five (5) calendar days from first date of possible or known exposure or two shift for Fire personnel.
4. Peace Officer- Police officers [may include others, such as marshals, some of whom may be elected] licensed by the Texas Commission on Law Enforcement and employed by

the city. (Ref. Texas Local Gov't Code 180.008(a); 143.003(4)(A); Tex. Health & Safety Code 121.021; Tex. Code Crim. Pro. Art. 2.12.)

C. RESPONSIBILITIES

1. Quarantine Leave

- a. A City of Leon Valley fire fighter, peace officer, or emergency medical technician who is ordered to quarantine or isolate by the person's supervisor or the city's [or county's if no city authority] health authority due to a possible or known exposure to a communicable disease while on duty is entitled to receive paid quarantine leave for the duration. (Ref. Texas Local Gov't Code 180.008(c).)
- b. The City of Leon Valley will not reduce a firefighter's, peace officer's, or emergency medical technicians sick leave, vacation, holiday, or other paid leave balance in connection with paid quarantine leave taken in accordance with this policy.

D. PROCEDURE

1. Eligible employees may request paid Quarantine Leave benefits as follows:

- a. The employee must notify their supervisor of the need for Quarantine Leave as soon as possible but no later than two days of an exposure or onset of symptoms. Within these two days, the employee shall seek medical testing and/or treatment by a medical physician, hospital or medical provider.
- b. The employee must also complete the Quarantine Leave Request Form (Attachment B) and turn it into their supervisor, along with any medical results or physician orders. The supervisor will then turn in their completed Request Form to the Human Resources Department.
- c. The supervisor or Department Head must complete a DWC 1 Employers First Report of Injury or Illness form (Attachment A), and return the form to the Human Resources Department within 3 days of being informed by the employee of a possible exposure.
- d. The Human Resources Department will submit the DWC 1 form to the workers' compensation insurance.
- e. Once the workers' compensation insurance receives the request, the workers' compensation insurance will determine if the employee requires further quarantining or isolating and if the employee should be reimbursed for any reasonable costs related to the quarantine or isolation. The workers' compensation insurance decision is final.

Send the specified copies to your Workers' Compensation Insurance Carrier and the injured employee.

*Employers - Do not send this form to the Texas Department of Insurance, Division of Workers' Compensation, Unless the Division specifically requests a direct filing.

CLAIM # _____

CARRIER'S CLAIM # _____

EMPLOYERS FIRST REPORT OF INJURY OR ILLNESS (DWC Form-001)

1. Name (Last, First, M.I.)		2. Sex F <input type="checkbox"/> M <input type="checkbox"/>	
3. Social Security Number - -	4. Home Phone ()	5. Date of Birth (m-d-y) - -	
6. Does the Employee Speak English? If No, Specify Language Yes <input type="checkbox"/> No <input type="checkbox"/>			
7. Race White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/>		8. Ethnicity Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> Other <input type="checkbox"/>	
9. Mailing Address Street or P.O. Box City State Zip Code County			
10. Marital Status Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/>			
11. Number of Dependent Children		12. Spouse's Name	
13. Doctor's Name			
14. Doctor's Mailing Address (Street or P.O.Box) City State Zip Code			

15. Date of Injury (m-d-y) - -	16. Time of Injury : am <input type="checkbox"/> pm <input type="checkbox"/>	17. Date Lost Time Began (m-d-y) - -	
18. Nature of Injury*		19. Part of Body Injured or Exposed*	
20. How and Why Injury/Illness Occurred*			
21. Was employee doing his regular job? YES <input type="checkbox"/> NO <input type="checkbox"/>		22. Worksite Location of Injury (stairs, dock, etc.)*	
23. Address Where Injury or Exposure Occurred Name of business if incident occurred on a business site Street or P.O. Box County City State Zip Code			
24. Cause of Injury(fall, tool, machine, etc.)*			
25. List Witnesses			
26. Return to work date/or expected (m-d-y) - -	27. Did employee die? YES <input type="checkbox"/> NO <input type="checkbox"/>	28. Supervisor's Name	29. Date Reported (m-d-y) - -

30. Date of Hire (m-d-y) - -	31. Was employee hired or recruited in Texas? YES <input type="checkbox"/> NO <input type="checkbox"/>	32. Length of Service in Current Position Months ____ Years ____	33. Length of Service in Occupation Months ____ Years ____
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34. Employee Payroll Classification Code	35. Occupation of Injured Worker
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36. Rate of Pay at this Job \$ ____ Hourly \$ ____ Weekly	37. Full Work Week is: ____ Hours ____ Days	38. Last Paycheck was: \$ ____ for ____ Hours or ____ Days	39. Is employee an Owner, Partner, or Corporate Officer? YES <input type="checkbox"/> NO <input type="checkbox"/>
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40. Name and Title of Person Completing Form		41. Name of Business	
42. Business Mailing Address and Telephone Number Street or P.O. Box Telephone ()		43. Business Location (If different from mailing address) Number and Street	
City State Zip Code		City State Zip Code	

44. Federal Tax Identification Number	45. Primary North American Industry Classification System Code:(6 digit)	46. Specific NAICS Code (6 digit)	47. Texas Comptroller Taxpayer No.
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48. Workers' Compensation Insurance Company	49. Policy Number
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50. Did you request accident prevention services in past 12 months? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, did you receive them? YES <input type="checkbox"/> NO <input type="checkbox"/>	
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51. Signature and Title (READ INSTRUCTIONS ON INSTRUCTION SHEET BEFORE SIGNING) X _____ Date _____	
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QUARANTINE LEAVE REQUEST FORM

Employee Name

Employee ID

I am a Leon Valley certified Peace Officer, Firefighter/ Emergency Medical Technician and am required to quarantine or isolate due to a possible or known exposure to a communicable disease while on duty. My current work schedule is (days/hours per day): _____.

I am requesting paid quarantine leave from (date) _____ to (date) _____, totaling _____ work hours.

I am also requesting reimbursement of reasonable costs related to quarantine or isolation deemed necessary by the City of Leon Valley, including lodging, medical, and transportation as follows: _____

The Employee whose signature appears below:

- (i) acknowledge I may be unable to return to work until such time as I provide a doctor's note signifying fitness to return to work if appropriate and as requested;
- (ii) understand that I still need to abide by my Department's call in procedures;
- (iii) certify that my Quarantine Leave Request is due to the reason(s) checked above; and
- (iv) understand that providing false or misleading information about my absence may result in disciplinary action up to and including termination.

Employee Signature: Date:

Department Head or Designee: Date:

Print Name of Department Head or Designee: _____

To be filled out by Human Resources Department. The above quarantine leave request has been:

Denied: Employee is not required to self-quarantine or isolate due to possible or known exposure to a communicable disease while on duty.

Approved:

Employee is entitled to quarantine leave for the duration of the quarantine or isolation period from:

(date) _____ to (date) _____

Employee is entitled for reimbursement of reasonable costs related to quarantine or isolation:

For: _____ date(s)

For: _____ date(s)

For: _____ date(s)

For: _____ date(s)

(To receive reimbursement, Employee must submit receipts the City's Travel Policy A23 will govern reimbursement request.

Approved By: _____

Date: _____