

## Hourly Application for Paid Infectious Disease Emergency Leave (Paid IDEL)

Team Member Name: \_\_\_\_\_ EE #: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

(check ONE of the boxes below):

This application is for myself OR  This application is for care and support of an eligible dependent

If applicable: Name of Dependent \_\_\_\_\_ Relationship to you \_\_\_\_\_

I am requested Paid IDEL for the following day(s): \_\_\_\_\_ for the reason(s) below:

1.  Under medical investigation, supervision, or treatment related to COVID-19
2.  Attending a vaccination appointment during my scheduled shift
3.  Experiencing a side effect from a COVID-19 vaccination
4.  Under direction from the CAMI Health Centre, medical practitioner, or other authority to self-isolate

Please provide any additional details to support your request: \_\_\_\_\_

### Declaration:

This request is unrelated to non-essential travel and/or travel restrictions that prevent my return to Ontario.

I understand that substantiation may be requested (if available, you may voluntarily provide with this application).

I understand that misrepresentation of the reason for this request is subject to disciplinary action.

I understand that I am still required to contact the GM Canada Medical Central Call Line at 519-425-3105 for further instruction should I develop symptoms, have close contact with someone who has tested positive for COVID-19, or be confirmed positive for COVID-19.

I understand that my employer is required to share my personal information with the Ontario government, including date of birth, address, SIN, contact information, and paystub to administer the Worker Income Protection Benefit.

\_\_\_\_\_  
Team Member Signature

\_\_\_\_\_  
Date

**RETURN THIS FORM TO EMPLOYEE RELATIONS**

### FOR ADMINISTRATION PURPOSES:

Paid IDEL has been granted OR  Declined – Reason: \_\_\_\_\_

Hourly Rate: \_\_\_\_\_ Amount Paid (Max \$200) \_\_\_\_\_

\_\_\_\_\_  
ER Signature

\_\_\_\_\_  
Date