

PHILADELPHIA FIRE DEPARTMENT
HEADQUARTERS

GENERAL MEMORANDUM #21-45

April 16, 2021

TO : Officers and Members

REF/AUTHORITY : Human Resources Manager/Deputy Fire Commissioner

SUBJECT : **ACT 17**

Pennsylvania State legislature introduced an act on April 29, 2020 that benefits public safety employees, including Fire Service Emergency Medical Technicians, Paramedics, and Firefighters. The act, which is effectively a sick leave benefit, provides paid leave for the following:

1. The absence of an employee who contracted and has been diagnosed with Covid 19 as documented by PCR blood test or antigen test.
2. The absence of an employee that has been ordered to quarantine to comply with an order given by a contact tracer, doctor, or departmental safety officer.¹

The act ensures paid leave for up to 60 days per incident. Wages paid under Act 17 are taxable for federal, state and local purposes and employees will continue to accrue leave earnings. The Fire Department will apply FMLA concurrently for employees who suffer serious health effects as a result of a Covid 19 diagnosis.

Act 17 leave must be used consecutively, in relation to a finite period of illness or quarantine. Multiple occasions of quarantine or illness will require employees to reapply to use the benefit.

RESPONSIBILITY

MEMBER

Members requesting the use of Act 17 must:

- Complete the attached request form in its entirety. *'Unknown' is not an acceptable response for any question; estimate dates if needed.*
- Provide the supporting documentation (test result, doctor's/contact tracer's order indicating length of absence)
- Submit the completed form & documentation to your company officer

¹ An employee quarantining under Act 17 may be required to undergo & provide results for a Covid 19 test.

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NOTE: The “Act 17 of 2020” Leave Request form can be located on the “T” drive - Documentation, in the Approved Electronic Documents folder at <T:\Documentation\Approved Electronic Documents>

Members returning from the use of Act 17 for their own illness must:

- Provide Fire HR with any medical documentation authorizing the return to duty. Return to work appointments at the Medical Evaluation Unit are not required.

OFFICER RESPONSIBILTY

- Receive the form and review it to ensure it contains the details required above
- Upon confirmation of completeness, forward to PFD.HR@phila.gov
 - Due to the potential for personal health information being disclosed, these memos should not be forwarded through channels.
- Notate “Absent-Sick-Act 17” on the roll call(s) for the member for the date(s) he/she is using Act 17.

BY ORDER OF
ADAM K. THIEL
FIRE COMMISSIONER

CITY OF PHILADELPHIA - LEAVE UNDER 35 PA. C.S. § 57A02

REQUEST AND DOCUMENTATION FORM

To request benefits provided for by 35 Pa. C.S. § 57A02, otherwise known as “Act 17 of 2020,” please complete the following Request and Documentation Form and submit to your departmental Safety Officer as soon as possible, but not later than five (5) working days after the first workday missed. Approved paid ACT 17 leave will not start until an approved form is received. Payment of benefits under Act 17 of 2020 does not constitute acceptance of a workers’ compensation, Regulation 32, Heart and Lung or any other disability or retirement benefit.

Name (print) _____ Payroll # _____

PFD Fire Company/Platoon _____

The reason for this leave request is (check the appropriate reason below):

(1) I am subject to a federal, state, or local quarantine or isolation order related to COVID-19.

• Name of governmental entity ordering quarantine/isolation: _____

(2) I have been advised by a health care provider, or departmental safety officer/human resources professional to self-quarantine because I was exposed to a COVID-19 positive individual.

• Identify the health care provider’s name, specialty, and address: _____

• The exposure occurred on: _____

• I expect to return to work on: _____

(3) I have been diagnosed with COVID-19.

• Identify the diagnosing health care provider’s name, specialty, and address: _____

• I was symptomatic starting: _____

• I expect to return to work on: _____

Please attach to this form all supporting documentation, including, but not limited to a physician’s note, verifying the statements above.

I hereby certify that I am unable to work due to the qualifying reason identified above.

By signing this form, I certify that the above information is truthful and accurate:

Employee Signature: _____

Date: _____