**Request for Leave Under the Massachusetts COVID-19 Emergency Paid Sick Leave Law**

If you are seeking emergency sick leave due to the COVID-19 pandemic under the Massachusetts COVID-19 Emergency Paid Sick Leave Law, please complete this form in its entirety as soon as it is administratively practicable for you to do so following your knowledge that leave is needed. If leave is foreseeable you must provide notice as far in advance as possible. Failure to properly complete or timely remit this form may lead to the delay or denial of your leave request.

Please provide the following information:

**Full Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date(s) leave is requested or taken**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SSN**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Employee ID**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the applicable qualifying reason(s) for requested leave**:

I am unable to work or telework (if available) during the leave period requested for the following reason:

⃣ To care for *(check one)* € myself € my family member, who *(check one box below as applicable):*

* must self-isolate due to a diagnosis of COVID-19
* needs to obtain a medical diagnosis or need care or treatment for COVID-19 symptoms
* are subject to a quarantine order or similar determination by a local, state, or federal public official, a health authority having jurisdiction, or a healthcare provider

⃣ I need to obtain or recover from a COVID-19 immunization

⃣ I am unable to telework (if available) due to my own COVID-19 symptoms

**NOTE: If the above qualifying reason for leave overlaps with a qualifying reason for leave under the federal Family and Medical Leave Act (FMLA) or any other unpaid federal, state or local law, the leaves will run at the same time, where legally permissible.**

**Please provide the following information, as applicable**:

If you are taking leave for yourself or your family member due to a quarantine order or self-quarantine advice, provide either the *name of the governmental entity ordering quarantine* or the *name of the healthcare provide*r advising self-quarantine (failure to provide this information when needed will delay the review of your leave):

*Name of entity ordering quarantine*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Name of healthcare provider*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are taking leave to care for a family member, provide the family member’s name and your relationship to the family member.

*Name*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Relationship*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employee Attestation**:

I understand that providing false or misleading information regarding the need for leave under the MA COVID-19 EPSL may result in disciplinary action, up to and including termination of employment.

I further acknowledge that leaves of absence may be concurrently charged against my entitlement(s) to leave under all applicable federal, state and local laws, and that all requests are subject to approval by Human Resources **[or insert name/contact details for appropriate company representative or department]**.

I certify that I am not able to work or telework due to the reason(s) provided above. If I am taking leave to care for a family member, I certify that the family member qualifies as my (1) spouse, (2) domestic partner, (3) child, (4) parent, (5) grandchild, (6) grandparent, (7) a sibling or parent of my spouse or domestic partner, or (8) a person who stood in loco parentis to me when I was a minor child.

I further certify that the above statements are true and correct.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ / /   
Employee Signature Date

***TO BE COMPLETED BY EMPLOYER ONLY***:

Date form received:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of hours employee is entitled to MA COVID-19 EPSL Leave:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of weekly payment eligible for reimbursement from Massachusetts: 100% Another amount: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date application to Massachusetts for reimbursement was made?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_