North Attleborough Public Schools

Employee Request for Emergency Paid Sick Leave

An employee requesting Emergency Paid Sick Leave pursuant to Chapter 16 of the Acts of 2021, "An Act Providing for Massachusetts COVID-19 Emergency Paid Sick Leave" and who was out of work for the purposes described below between (May 28, 2021 and September 30, 2021) must complete this form. You must provide as much advance notice as reasonably practicable in order to apply for leave. Please submit this form to Cathy Calicchia, Human Resources Director via email at ccalicchia@nashools.net. We will accept forms for time you may have used prior to September.

I. Employee Information

Employee Name: _____ Title: _____

Dept/School: _____ Dept Head/Principal: _____

Employee Phone Number: _____ Employee E-Mail Address: _____

II. Requested Leave

Anticipated Begin Date of Leave: _____

Expected Return to Work Date: _____

Purpose for Leave:

I am/was unable to work (or telework) because of the following (select the most appropriate box and provide any additional required information).

☐ **Purpose 1**: I need to: (a) self-isolate or care for myself because I have been diagnosed with COVID-19; (b) get a medical diagnosis, care or treatment for COVID-19 symptoms; or (c) get or recover from a COVID-19 immunization.

a. Provide the reason for leave:
   - ☐ Self-isolation and/or care due to a COVID-19 diagnosis
   - ☐ Need to obtain a medical diagnosis, care or treatment for COVID-19 symptoms
   - ☐ Need to recover from a COVID-19 immunization

☐ **Purpose 2**: I need to care for a family member who: (a) must self-isolate due to a COVID-19 diagnosis; or (b) needs a medical diagnosis, care or treatment for COVID-19 symptoms.

a. Provide the name and relation to the family member:

_____

b. Provide the reason for leave:

☐ Self-isolation and/or care due to a COVID-19 diagnosis

☐ Need to obtain a medical diagnosis, care or treatment for COVID-19 symptoms

☐ Need to recover from a COVID-19 immunization

☐ **Purpose 3**: I am subject to a quarantine order or similar determination.

a. Provide the name of the governmental entity ordering quarantine or the name of the health care provider advising self-quarantine:

_____

☐ **Purpose 4**: I need to care for a family member subject to a quarantine order or similar determination.

a. Provide the name of and relation to the family member:

_____

b. Provide the name of the governmental entity ordering quarantine or the name of the health care provider advising self-quarantine:

_____

☐ **Purpose 5**: I am unable to telework due to COVID-19 symptoms.

a. Provide the status of your COVID-19 testing:

☐ Attempting to make an appointment for a COVID-19 test

☐ Waiting for a scheduled appointment for a COVID-19 test

☐ Awaiting results from a COVID-19 test

b. If you have been tested, please provide the date:

_____

c. I hereby certify that if I test positive for COVID-19 I will not return to work until cleared by my medical provider. If I use an electronic signature below it shall constitute my authentic signature.

Employee Signature: _____

III. Emergency Paid Sick Leave Benefit

Employees that regularly work forty (40) or more hours per week are entitled to up to forty (40) hours of paid sick time.

Employees that regularly work less than forty (40) hours per week will receive leave time in an amount equal to the average number of hours that the employee works per week.

Employees whose schedule and weekly hours vary from week to week will receive leave time in an amount equal to the average number of hours that the employee was scheduled to per week over the previous six (6) months. If such an employee has not worked for the School Department for at least six (6) months, the employee will receive leave time in an amount equal to the number of hours per week that the employee reasonable expected to work when hired.

No employee shall receive more than eight hundred and fifty ($850) dollars in total emergency paid sick leave pay. An employee that, based on their normal rate of pay, would receive greater than eight hundred and fifty ($850) dollars for forty (40) hours of week may use other accrued leave to make up the difference in pay.

If you are an employee that based on your normal rate of pay, would receive greater than eight hundred and fifty ($850) dollars for forty (40) hours of week, please check below in order to supplement the difference with your accrued leave:

☐ I hereby authorize the School Payroll Office to supplement my difference in pay with accrued sick leave. To the extent I have no sick leave available, I authorize the School Payroll Office to supplement my difference in pay with accrued vacation and/or personal leave time. If I use an electronic signature below it shall constitute my authentic signature.

Employee Signature: _____

IV. Certification

I hereby certify that the above information is accurate and complete.

Employee Signature: _____

Date: _____

FOR HR USE ONLY

Date Received: _____