New York State COVID-19 Paid Sick Leave
REQUEST FORM

Employee Name: _____

Date: _____

READ BEFORE COMPLETING: Current CDC and NYS Department of Health guidelines recommend a symptoms based approach to isolation for COVID-19. Under the current guidance, it is recommended that symptomatic individuals stay home and isolate until, for at least 24 hours, both of the following are true:

1. **Symptoms are improving overall (starting to feel better), and**
2. **Fever free (without needing fever-reducing medication to be fever-free)**

All questions must be completed:

1. My COVID-19 symptoms and/or fever started on _____ (date).
2. I tested positive for COVID-19 on _____ (date), and have attached a copy of my laboratory test or documentation from a licensed medical provider attesting that I tested positive for COVID-19.
3. First date of absence: _____ (date).
4. Last date of absence: _____ (date).

By signing below, I am attesting that the information I have provided is true and accurate. I understand that providing false or misleading information may result in disciplinary action.

_____ _____

Employee Signature **Date**

**Upon your return to work, this completed form and documentation of your positive test must be emailed to human_resources@ktufsd.org.*

Eff. April 29, 2024