



MIDDLEBOROUGH PUBLIC SCHOOLS

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Brian E. Lynch | **Sarah T. Hickey**
Superintendent of Schools | Director of Business & Finance

COVID-19 Emergency Sick Leave

Name: _____ Date: _____

Cell Phone: _____ Email: _____

I hereby certify that I need to use Emergency Paid Sick Leave because I cannot work or telework for one of the following reasons (CHECK ONE):

Emergency Sick Leave for Employee's Own Situation

_____ I am unable to work/telework because I am subject to a governmental quarantine or isolation order due to COVID-19 related concerns. Name of Governmental Entity Issuing Order _____

_____ I am unable to work/telework because I am experiencing symptoms of COVID-19 and seeking medical diagnosis. Name of Health Care Provider: _____

_____ I am unable to work/telework because I have been advised by a health care provider to self-quarantine due to concerns related to COVID-19. Name of Health Care Provider: _____

A leave under this provision will provides regular pay for 80 hours/2 weeks to a maximum of \$511 per day or \$5,110 total. I request that my accumulated time (sick/personal/vacation) if applicable, be used to make up the difference so that I receive my full pay.

Emergency Sick Leave to Care for an Individual

_____ I am unable to work/telework because I am required to care for an individual (not a son or daughter or foster child) who is subject to a governmental quarantine or isolation order. Name of Individual: _____ Relationship: _____
Name of Governmental Entity Issuing Order: _____

_____ I am unable to work/telework because I am required to care for an individual (not a son or daughter or foster child) who has been advised to self-quarantine due to concerns related to COVID-19. Name of Individual: _____ Relationship: _____
Name of Health Care Provider: _____

A leave under this provision provides you with 2/3 of your regular pay for 80 hours/2 weeks to a maximum of \$200 per day or \$2,000 total. I request that my accumulated time (sick/personal/vacation) if applicable, be used to make up the difference so that I receive my full pay.

First Date of Leave: _____ Anticipated Return to Work Date: _____

I understand that I may be required to provide additional documentation and/or a fitness to return to work certification. I acknowledge that it is my responsibility to contact Superintendent of Schools prior to returning to work. I also understand that if I am unable to return to work/telework on the above date. I must obtain approval for an extension of my leave. I certify that the information provided herein is accurate and true.

Signature: _____ Date: _____

“...to foster a culture of excellence within every student, in every classroom every day.”

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