EXTENDED FAMILY SICK LEAVE

All full-time employees shall be entitled up to five (5) days of sick leave in each calendar year when such employee has been exposed to a contagious disease or when there is a serious illness in the employee's ***immediate family*** (defined as spouse, child or parent).

City of Haverhill

I hereby request extended sick leave benefits to cover a serious illness or contagious disease in my immediate family.

Name of Employee: _____ Department: _____

The amount of time needed is _____ day(s). (Please circle) S M T W R F S

Date(s) from _____ to _____ .

The purpose of the request is to cover: (Please check) ☐ Serious Illness ☐ Contagious Illness

Name of Patient: _____ Relationship: _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize release of the medical information specified below to the Human Resources Director of the City of Haverhill. NOTE: If you are not the patient, parent or guardian of the patient, it is your responsibility to obtain the medical information from the responsible party.

Employee's Signature: _____ Date: _____

TO THE ATTENDING PHYSICIAN

Please complete this form and return it to: Human Resources Department, 4 Summer Street Room 306, Haverhill, MA 01830 or Fax @ (978) 374-2343.

Patient's name: _____

Please verify the above named employee has been exposed to a contagious disease or there is a serious illness in the immediate family. ☐ YES ☐ NO

Please indicate the anticipated duration of absence of employee due to this illness:
(Please circle) S M T W R F S Date(s) from _____ to _____

Diagnosis of patient: _____

_____

_____

Physician's Name: _____ Signature: _____ Date: _____

Address: _____ Telephone: _____

Proof of such illness in the form of a doctor's statement shall be presented before payment of compensation is made.

Original – Human Resources Department cc: Employee's Department, Employee