



PAID TIME OFF VERIFICATION NYS DBL/PFL

If wages are paid to employee during a period of disability or leave, submit with completed employer's statement

- Disability Claim
- Paid Family Leave Claim

Employee Name: _____

- Sick Time: From: _____ to: _____
- Vacation Time: From: _____ to: _____
- Personal Time: From: _____ to: _____
- PTO (Paid Time Off): From: _____ to: _____
- Salary Continuation: From: _____ to: _____

IF REQUESTING REIMBURSEMENT, PLEASE INDICATE ON THE CLAIM FORM.

By: X _____ **Date:** _____
(signature) (mm/dd/yyyy)

Title: _____ **Phone:** _____

Notes:

FOR QUESTIONS: 844-368-6485