



## 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: \_\_\_\_\_

**IF REQUESTING REIMBURSEMENT, PLEASE INDICATE ON THE CLAIM FORM.**

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

**Title:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Notes:**