DEPARTMENT OF FAMILY AND MEDICAL LEAVE
AFFIDAVIT OF QUALIFYING FAMILY RELATIONSHIP

Claimant's Name: _____

Claimant's NTN: _____

You have received this Affidavit of Qualifying Family Relationship because you have applied to the Massachusetts Department of Family and Medical Leave for family leave benefits either (1) to care for a family member with a serious health condition or (2) to manage a qualifying exigency arising from your family member's call to active duty.

The Department requires additional information and documentation of your relationship to the individual whose situation necessitates your leave. For more information on the family members who are covered under the Paid Family and Medical Leave law (PFML), please visit https://www.mass.gov/info-details/paid-family-and-medical-leave-pfml-benefits-guide#about-family-leave-to-care-for-a-family-member-

Please complete this form and attach any relevant documentation, if available. The completed form and documentation must be mailed or faxed to us at:

Department of Family and Medical Leave
P.O. Box 838
Lawrence, MA 01842
Fax: 617-855-6180.

If you cannot fax or mail the form, please call our Contact Center at (833) 344-7365.

Family Member Name: _____

Relationship to Claimant ("This person is my…"): _____

Family Member's Date of Birth: _____

Please select all that apply and sign below.

☐ In order to verify that our relationship entitles me to family leave, I have attached a copy of the following documentation as proof of the relationship between the individual named on this form and me:

- ☐ Birth Certificate
- ☐ Marriage Certificate
- ☐ Court document: _____
- ☐ Other: _____

☐ I am unable to provide relevant supporting documentation.

I certify under penalty of perjury that the information contained in this form is true and correct and that the individual named on this form, whose situation necessitates my leave, is a covered family member under the PFML law.

Claimant Signature: _____ Date: _____