

**COUNTY OF SULLIVAN  
DIVISION OF HEALTH & FAMILY SERVICES**



*Public Health Services*  
GLADYS OLMSTED BUILDING  
50 COMMUNITY LANE  
LIBERTY, NY 12754



**Public Health**  
*Prevent. Promote. Protect.*  
Sullivan County  
Public Health Services

**AFFIRMATION OF QUARANTINE**

*(Complete one form for each person)*

Complete this form if you or your child:

1. Have been identified as a close contact to a COVID-19 positive person during their contagious period, and
2. Was not fully vaccinated (including being eligible for booster and not yet boosted) at the time of exposure to a COVID-19 positive person during their contagious period, and
3. Have been in quarantine.

I, (print name) \_\_\_\_\_, do hereby affirm that I or my child quarantined from (date) \_\_\_\_\_ through (date) \_\_\_\_\_ consistent with guidance issued by the New York State Department of Health (NYSDOH) and Centers for Disease Control and Prevention (CDC). As per NYSDOH and CDC guidance, I or my child was identified as a close contact to a COVID-19 positive person during their contagious period and was not fully vaccinated at the time of exposure. Release from Quarantine includes the following option:

1. I or my child quarantined for five (5) days following the last day of exposure to the COVID-19 positive person and have remained asymptomatic during the ten (5) days and will wear a well-fitting mask while around others for an additional five (5) days.

Day 1 of quarantine begins the day after my or my child's last day of exposure to the COVID-19 positive person.

Name of Person in Quarantine: \_\_\_\_\_

Date of Birth of Person in Quarantine: \_\_\_\_\_

Last Day of Exposure to the COVID-19 Positive Person: \_\_\_\_\_

Affirmed under penalties of perjury by me on (today's date) \_\_\_\_\_.

\_\_\_\_\_  
(SIGNATURE)

PLEASE NOTE: YOUR SIGNATURE DOES NOT HAVE TO BE WITNESSED BY A NOTARY PUBLIC; YOU ARE AFFIRMING THE VERACITY OF THE INFORMATION YOU HAVE PROVIDED ON THE FORM.

**If completed fully and accurately, based solely on such provided information which I accept as fact, I, Nancy McGraw, Director, Sullivan County Public Health Services, do hereby find that the affirming individual herein has met the criteria for quarantine if the date this form is affirmed is more than required number of days (as consistent with the above requirements) from the listed quarantine period onset date.**

A handwritten signature in cursive script that reads "Nancy McGraw".

Nancy McGraw  
Public Health Director

This form may be used for Quarantine Release or for New York Paid Family Leave COVID-19 claims as if it was an individual Order for Isolation issued by the Director of Sullivan County Public Health Services.

*Updated 1/12/2022*