

State Employees Employee-to-Employee Leave Program - Submitting Requests for Leave

This packet contains information and all forms necessary to request leave from the Employee-to-Employee Leave Donation Program:

1. Fact Sheet for the Employee-to-Employee Leave Donation Program– Contains general information about donating and receiving leave from the Employee-to-Employee Leave Donation Program.
2. Employee-to-Employee Leave Donation Program Request Form (MS-405) – Please complete Part I if you are donating Leave to another employee, submit to your Personnel Office and provide a copy to the employee to whom you are making the donation. If you are requesting Leave from another employee, complete Part I and submit to your Personnel Office.
3. Employee-to-Employee Leave Donation Program Medical Request Form (MS-402 E-to-E) – Please have your treating physician(s) complete and submit to Personnel Office.
4. Authorization Form for Release of Records & Information (HIPAA Form) – Please complete and submit to your Personnel Office.
5. Employee-to-Employee Leave Donation Program – Medical Documentation – Provides examples of medical records that should be provided by your treating physician(s) to support your request

MEDICAL RECORDS

Medical records that address and support your work absence are the best documentation to provide for favorable consideration of your request. For example, if you need leave to cover your absence from January 1 to January 15, ask your treating physician(s) to submit **actual medical records** that address the period from January 1 to January 15. It is not necessary for your physician to write any additional notes or letters.

FACT SHEET

EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

FOR EMPLOYEES DONATING LEAVE TO OTHER EMPLOYEES:

- Employees may voluntarily donate unused annual, sick or personal leave to another employee.
- An employee who donates sick leave to another employee must maintain a sick leave balance of at least 240 hours after the donation is deducted.
- An employee who donates leave shall designate the recipient of the leave.
- If an employee who receives leave does not use all of the donated leave, the remaining hours of leave shall be automatically transferred to the State Employees' Leave Bank.

To donate leave to another employee, please complete Part I of the State Employees' Leave Donation Form (MS-405) and submit the form to your Personnel Office. You should also provide a copy of the form to the employee to whom you are making the donation. The form is available from your Personnel Office or on the Department of Budget and Management website at www.dbm.maryland.gov.

FOR EMPLOYEES RECEIVING LEAVE FROM OTHER EMPLOYEES:

To qualify for leave from the Employee-to-Employee Leave Donation Program, an employee must:

- have exhausted all available annual, personal, sick and compensatory leave because of:
 - 1) a personal serious and prolonged medical condition that exists at the time the leave is donated; or
 - 2) a catastrophic illness or injury of a member of the employee's immediate family for whom the employee is needed to provide direct care. Catastrophic illness or injury is defined as a condition that is incapacitating or life threatening as certified by a health care provider. An employee may use leave from another employee to care for a family member only after obtaining approval from the employee's appointing authority. The appointing authority's approval is **discretionary** and denial may be based on any reason which is consistently applied and is not illegal or unconstitutional.
- qualify for the use of sick leave under the requirements of the employee's personnel system;
- must provide sufficient medical documentation to substantiate absence for the time period covered by the Employee-to-Employee Leave request;
- in all likelihood be able to return to work;
- have received less than 2,080 hours of leave from the Leave Bank and the Employee-to-Employee Leave Donation Programs; and
- **not** have used more than 16 continuous months of leave from the Leave Bank, Employee-to-Employee Leave Donation Program and all other forms of paid leave.

To request leave from another employee, please complete Part II of the State Employees' Leave Donation Form (MS-405) and submit the form to your Personnel Office. You must also have the treatment provider complete an Employee-to-Employee Leave Donation Program Medical Request Form (MS-402 E-to-E) and provide medical records that address the absence for which Employee-to-Employee Leave is requested. The forms are available from your Personnel Office or on the Department of Budget and Management website at www.dbm.maryland.gov. Please submit completed forms and medical documentation to your Personnel Office.

If an employee who receives leave does not use all of the donated leave, the remaining hours of leave shall be automatically transferred to the State Employees' Leave Bank.

(February 2013)

EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM - REQUEST FORM

**FORM TO BE COMPLETED TO DONATE LEAVE TO ANOTHER STATE EMPLOYEE
OR RECEIVE DONATED LEAVE FROM ANOTHER STATE EMPLOYEE**

COMPLETE PART I IF DONATING LEAVE TO ANOTHER EMPLOYEE

PART I

EMPLOYEE MAKING THE LEAVE DONATION:

NAME: _____ *SOCIAL SECURITY #: _____

** Providing your full Social Security Number will help us to verify your identity. Failure to provide it may result in rejection of your request. Your number will be kept confidential in accordance with Federal and State laws and regulations.*

AGENCY: _____ AGENCY CODE: _____

TYPE OF LEAVE DONATED: SICK** NUMBER OF HOURS: _____

*** If you are donating sick leave, you must maintain a balance of at least 240 hours of sick leave after the donation is deducted.*

ANNUAL NUMBER OF HOURS: _____

PERSONAL NUMBER OF HOURS: _____

I AM DONATING THIS LEAVE TO:

EMPLOYEE'S NAME: _____ *SOCIAL SECURITY #: _____

** Providing your full Social Security Number will help us to verify your identity. Failure to provide it may result in rejection of your request. Your number will be kept confidential in accordance with Federal and State laws and regulations.*

AGENCY: _____ AGENCY CODE: _____

I understand that if the employee to whom I am donating leave does not use the leave for any reason, the unused donated leave is forfeited to the State Employees' Leave Bank.

Signature: _____ Date: _____

CERTIFICATION OF DONATING EMPLOYEE'S APPOINTING AUTHORITY/TIMEKEEPER

As the appointing authority/timekeeper for the employee making the above leave donation, I certify this donation is in compliance with COMAR 17.04.11.22C(3).

Signature: _____ Date: _____

HAVE YOUR APPOINTING AUTHORITY/TIMEKEEPER COMPLETE PART II IF YOU ARE RECEIVING DONATED LEAVE FROM ANOTHER EMPLOYEE

PART II

CERTIFICATION OF RECEIVING EMPLOYEE'S APPOINTING AUTHORITY/TIMEKEEPER

As the appointing authority/timekeeper for the employee receiving the above leave donation, I certify that the employee has not received more than a total of 2080 hours of donated leave from the State Employees' Leave Bank and/or the Employee-to-Employee Leave Donation Programs during the employee's State service. I further affirm that the employee has not used donated leave for a continuous period that exceeds 16 months when combined with all other forms of paid leave.

Signature: _____ Date: _____

**EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM
MEDICAL REQUEST FORM**

TO BE COMPLETED BY EMPLOYEE'S TREATING PHYSICIAN

PATIENT'S NAME: _____

DIAGNOSIS(ES): _____

ICD-9 CODE(S): _____

SUMMARY OF TREATMENT(S) & PROCEDURE(S): _____

CPT CODE(S): _____

SURGERY DATE (IF APPLICABLE): _____

HOSPITALIZATION DATE(S) (IF APPLICABLE): From: _____ To: _____

CAN EMPLOYEE WORK IN A MODIFIED CAPACITY? YES _____ NO _____

IF YES, EXPLAIN RESTRICTIONS FOR MODIFIED DUTY:

DATE EMPLOYEE IS LIKELY TO RETURN TO:

MODIFIED DUTY: _____ **FULL DUTY:** _____

PHYSICIAN'S SIGNATURE

PHYSICIAN'S NAME (PRINTED)

PHYSICIAN'S PHONE NUMBER

DATE FORM COMPLETED

This document shall be treated as a confidential medical record; it shall not be placed in the employee's personnel file. Only those individuals with a need to know this information will be given access to it. An employee who fails to appropriately safeguard the confidentiality of this information will be subject to disciplinary action, including termination from State Service.

EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

Authorization Form for Release of Records and Information

- A. Identification:** This document authorizes the use and/or disclosure of confidential protected health information about the following person:

Employee's Name: _____ Date of Birth: _____

B. Directions for Release:

I authorize the individual or company identified below in Section B.1b to release and/or use protected health information pertaining to the individual listed in Section A to the individual(s) identified in Section B.1a.

B.1a. I authorize the disclosure of information to:

My Appointing Authority or Designee
State of Maryland Employee-To-Employee Leave Donation Program
State Medical Director

B.1b. I authorize the obtaining of information from:

(Specify Health Care Provider) _____
State Medical Director

- B.2. Information to be released:** I authorize the disclosure and/or use of any information from my medical records relating to the condition(s) for which I am seeking leave.

B.3. Purposes: I authorize the disclosure and/or use for the following reason(s):

- (a) for employment purposes
- (b) to determine my eligibility for participation in the State of Maryland Employee-To-Employee Leave Donation Program

- B.4.** I am asking that you NOT provide any genetic information when responding to this request for medical information. Genetic information, as defined by the Genetic Information Nondiscrimination Act of 2008, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

- C. Right to Revoke:** I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance upon it. This authorization will expire one year after the date it is signed. To revoke the authorization, I must contact, in writing: Jennifer Hine, Director, Personnel Services, Department of Budget and Management, 301 W. Preston Street, Room 602, Baltimore, MD 21201 or via Fax at 410-333-5440.

- D. Authorization and Signature:** I authorize the release of my confidential protected health information, as described in my directions in Section B. I understand that this authorization is voluntary, the information to be disclosed is protected by law and the disclosure will conform with my directions. The information that is used and/or disclosed pursuant to this authorization may be redisclosed by the recipient unless the recipient is covered by Maryland law which prohibits redisclosure or other laws limiting the use and/or disclosure of my confidential protected health information.

I have read the contents of this authorization and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

Your Signature

Signature of Witness

Date

(Revised May 2015)

EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

MEDICAL DOCUMENTATION

In most situations, your leave request will be evaluated without benefit of a personal examination. Please have your health care provider(s) submit appropriate medical documentation to support your request. The best thing to submit for favorable consideration is medical documentation that addresses the period of time you need leave.

Listed below are examples of the type of medical documentation that should be submitted, if applicable:

1)	Office Visit Notes
2)	Hospital Records (Operative Report & Discharge Summary)
3)	Physical & Diagnostic Findings
4)	Physician's Statement Of Current Disability, Symptoms And Physical Limitations (to explain why you cannot perform your job duties) and Prognosis
5)	Laboratory Reports (EEG, Myelogram, Angiography, Cat Scan, Etc.)
6)	Reports Of X-Rays As Read By Examining Physician
7)	Physical Therapy Notes
8)	Reports from Specialists
9)	Date of Surgery or Other Procedure
10)	For Pregnancy Cases, Anticipated Due Date or Actual Delivery Date, Type of Delivery and Copy of Antepartum Record

(Revised February 2013)