

# STATE EMPLOYEES LEAVE BANK REQUEST FORM

## TO BE COMPLETED BY EMPLOYEE *(Please TYPE or PRINT)*

Name*:	Workday#: W _ _ _ _ _	Agency Hire Date:
* Your full Name and Workday Number (W#) are <u>required</u> to help verify your identity and process your Request. Failure to provide it may result in delays and/or rejection of your request.		
Job Title <u>and</u> brief description of duties ( <b>Required</b> ):		State Hire Date:
Home Address:	City/State/Zip:	
Personal Email:	Request Type: <input type="checkbox"/> New <input type="checkbox"/> Extension <input type="checkbox"/> Updated	
Employee Signature:	Date:	

## TO BE COMPLETED BY AGENCY HR/LEAVE BANK COORDINATOR

Leave Bank Coordinator:	Email:
Phone #:	Full Agency Name:
Last Date Employee Worked:	Leave Bank Membership Expiration Date**:
Hours Needed (after EE leave is exhausted):	Dates to Cover: From _____ To: _____
Can agency accommodate a modified duty assignment? No <input type="checkbox"/> Yes <input type="checkbox"/>	
Is employee on FMLA leave? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, provide end date of current FMLA:	
Has employee been on one-day sick slip restriction within the last two years? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, provide effective date of restriction:	
Has employee been disciplined within the last year? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, provide effective date of disciplinary action:	
Employee's last performance evaluation rating was: <input type="checkbox"/> Satisfactory or Above <input type="checkbox"/> Less than Satisfactory	
Is this absence due to an on-the-job injury? No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, Contact DBM Leave Bank Program Manager	
Has the employee been seen by the State Medical Director? No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, Provide copy of Medical Report	
Has the employee applied for Disability Retirement? No <input type="checkbox"/> Yes <input type="checkbox"/> If Yes, Provide copy of signed SRA 129	
Leave Bank Coordinator's Signature:	Date:

**\* COPY OF MOST CURRENT LEAVE BANK MEMBERSHIP FORM IS REQUIRED \***

## COMPLETED BY APPOINTING AUTHORITY OR DESIGNEE

**This employee has exhausted all forms of annual, sick, personal, and compensatory time because of a serious and prolonged medical condition.** The employee has been a member of the Leave Bank for at least 90 days or has been granted an exemption by the Secretary of Budget and Management. Approval will not cause the employee to exceed 2,080 hours of leave from the Leave Bank and Employee-to-Employee Leave Donation Programs during his/her entire State employment. Approval will not cause the employee to exceed 16 months of continuous leave, when combined with all other forms of paid leave. **As the appointing authority for this employee, I have reviewed the employee's records and I certify that this request meets all the criteria specified in this Section.**

\_\_\_\_\_  
Signature of Appointing Authority or Designee

\_\_\_\_\_  
Date