STATE EMPLOYEES' LEAVE BANK ENROLLMENT FORM

EMPLOYEE TO COMPLETE *(Please **TYPE** or **PRINT**)*

Please complete this form if you wish to donate leave to **JOIN (within first 60 days)** or **RENEW (during Open Enrollment)** your membership in the State Employees' Leave Bank.

NAME*: _____ **SS#*:**_____

***You must provide your full Name and Social Security Number to help us verify your identity. *Failure to to do so may result in rejection of your membership.* Your number will be kept confidential in accordance with Federal and State laws and regulations.**

FULL AGENCY NAME: _____ **HIRE DATE:**_____

If you are joining the Leave Bank for the **FIRST TIME**, you must be a member for at least **90 days before you are eligible** to RECEIVE leave.

TYPE OF LEAVE	DONATED HOURS	NEW BALANCE
Personal		
Annual**		
Sick***		

APPLICATION STATUS (√)	
○	**INITIAL – OPEN ENROLLMENT**
○	**INITIAL – NEW HIRE (First 60 days)**
○	**RENEWAL – OPEN ENROLLMENT**
○	**REHIRE**

I hereby certify that I agree to donate eight (8) hours of sick, annual or personal leave, or a combination thereof, to establish membership in the State Employees' Leave Bank Program. ***By participating I understand that I will be a member for two (2) years from the effective date of enrollment.***

_____ _____

SIGNATURE OF EMPLOYEE **DATE**

**** New State of Maryland employees are not eligible to donate Annual Leave until they have at least six months of State Service.**

*****State of Maryland employees are not eligible to donate Sick Leave unless they will have a balance of at least 240 hours after donation.**

APPOINTING AUTHORITY/DESIGNEE TO COMPLETE

☐ **ANNUAL/PERSONAL LEAVE CERTIFICATION:** I have reviewed this employee's leave balances and affirm that s/he has sufficient annual/personal leave to make this donation.

☐ **SICK LEAVE CERTIFICATION:** I have reviewed this employee's sick leave balance. ***I affirm that s/he will have a sick leave balance of at least 240 hours after this donation is subtracted***.

_____ _____

APPOINTING AUTHORITY/DESIGNEE **DATE**

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☐ **___ Hrs of selected Leave was removed from balance on _____ by _____/_____**

 # Date Print/Initial

(Note: Leave must be adjusted within seven (7) days per COMAR 17.04.11.23)