STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

INSTRUCTIONS FOR SUBMITTING AN EMPLOYEE-TO-EMPLOYEE DONATION LEAVE REQUEST

This packet contains information and all forms necessary to request leave from the Employee-to-Employee Leave Donation Program. **PLEASE REVIEW BEFORE COMPLETING**:

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 Packet includes the following **required** forms:

   - **Request Form** - MS405 (**always use most current forms from the DBM Website**)

   - **Part I** – To be completed by employee **donating** leave and their Agency Appointing Authority.
   - **Part II** - To be completed by **receiving** employees' **Certified Leave Bank/Employee-to-Employee Leave Coordinator** (HR Office) and their Agency Appointing Authority; **must be for a serious and prolonged medical condition (not for Intermittent Leave**). *If not, please stop and contact your HR Office.*

   - **Medical Certification Form** (MS402-EE) – Please have your treating physician(s) complete; a "**Full Return Date**" **MUST** be provided with the completed form to avoid delays in reviewing. Submit the medical form with Form MS 405 and the HIPAA form to your HR Office.

   - **Authorization Form to Review Records & Information** (HIPAA Form) – Please sign, date and submit, with the MS 402 and MS 405, to your HR Office.

   - **Medical Documentation List** –Provides examples of medical records that should be provided by your treating physician(s) to support **only the dates for which you are requesting leave.** Have your physician provide you with as much additional medical documents as possible for the period of leave that is being requested to ensure a proper review and determination.

     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 provide **actual medical records** that address the period from January 1 to January 15. Or you can pull records for the dates requested from your online medical account accordingly.

     ****If your request is for surgery, proof of surgery must be provided upon your initial request or immediately following your surgery. Requests are denied for failing to provide this information.***

STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

FACT SHEET

FOR EMPLOYEES DONATING LEAVE TO OTHER EMPLOYEES:

- Employees may voluntarily donate unused annual, sick or personal leave to another employee **who has a serious and prolonged medical condition**.
- 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 **who is in current need of leave for a serious and prolonged (not intermittent) medical condition**.
- If an employee who receives leave does not use all of the donated leave, **the remaining hours of leave shall be returned to the employee(s) who made the donation(s).**
- To donate leave to another employee, **please complete Part I** of the State Employees' Leave Donation Form (MS405) and submit the form to your HR Office for certification of leave. You should also provide a copy of the form to the employee to whom you are making the donation after the leave has been certified. The form is available from your HR 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** (**not intermittent**) 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.***
- must provide sufficient medical documentation to support the absence for the period of leave requested by the Employee.
- **must** 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.
- **is not** a member of the Leave Bank (does not apply to requests for care of immediate family members); **current LB members** must request leave from the leave bank for their personal illness**.**
- **qualify for the use of sick leave under the requirements of the employee's personnel system.**

To request leave from another employee, please review the previous instructions and have all the required forms completed and submit to your HR Office. Failure to properly have the forms completed may results in an unfavorable determination. USE THE MOST CURRENT Forms which are available from your HR Office or on the Department of Budget and Management's website at www.dbm.maryland.gov.

(Rev. 4/2025)

EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM - REQUEST FORM

PART I - TO BE COMPLETED BY DONATING EMPLOYEE *(Please **TYPE or PRINT** with black or blue Ink)*

Name of **Donating** Employee*:	W# of **Donating Employee***:	State Hire Date:

** Your **full** Name and Workday Number (W#) are required to help verify your identity. Failure to provide it may result in delays and/or rejection of this request. This information is kept confidential.*

Donating Employee's Agency Name:	Agency Leave Coordinator:

RECEIVING EMPLOYEE'S INFORMATION:

Name of Employee:	Employee's Agency Name:	Employee's W#:

TYPE OF LEAVE DONATED:	**TOTAL HOURS DONATED:**	**LEAVE BALANCE AFTER DONATION:**
[ ] SICK**		
[ ] ANNUAL		
[ ] PERSONAL		

I understand that if the employee to whom I am donating leave does not use the leave for any reason, ***the unused donated leave shall be returned to my leave balances by my Appointing Authority.***

Signature:	**Date:**

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

CERTIFICATION OF LEAVE FOR DONATING EMPLOYEE – TO BE COMPLETED BY APPOINTING AUTHORITY/DESIGNEE

☐ 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.** As the Appointing Authority/Designee for the employee making the above leave donation, I certify this donation is in compliance with COMAR 17.04.11.22 C (3).

_____ _____

APPOINTING AUTHORITY/DESIGNEE DATE

*(Per COMAR 17.04.11.22 C (11) The appointing authority of an employee who donates leave shall adjust the donating employee's leave balance **before** forwarding a copy of the MS 405 form to the receiving employee's appointing authority. **If the receiving employee is denied** the use of donated leave, the receiving employee's appointing authority shall notify the donating employee's appointing authority within 7 days of the denial, and the donating employee's appointing authority **shall restore the leave balance of the donating employee** within 14 days of notification from the receiving employee's appointing authority.)*

*******************NOT VALID WITHOUT TIMEKEEPER CERTIFICATION*******************

☐ ***Hrs of selected LEAVE DONATED were deducted from balance on _____ by _____/_____***

Print Name! (!Required) / Initials

EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM - REQUEST FORM

PART II - TO BE COMPLETED BY EMPLOYEE RECEIVING LEAVE DONATIONS

(*Please **TYPE or PRINT** with Black or Blue ink)*

Name*: (Ms/Mr)	**Workday #*: W** ___ ___ ___ ___ ___ ___ ___
** Your full Name and Workday Number (W#) are **required** to help verify your identity and process your Request. Failure to provide it may result in delays and/or rejection of your request. This information is kept confidential.*	
Job Title and brief description of duties:	
Home Address:	City/State/Zip:
Agency Name:	Request Type: ☐ New ☐ Extension
Reason for Request: ☐ An illness or disability of the employee due to *a serious and prolonged medical condition that existed at the time the leave was donated*; **or**	
☐ A catastrophic illness or injury of a member of the employee's immediate family for whom the employee is needed to provide direct care**.	
****For family member please provide - Name:**	**Relationship:**
****Describe care to be provided:**	
Signature:	**Date:**

MUST BE COMPLETED BY AGENCY LEAVE BANK/DONATION COORDINATOR

Leave Bank/Donation Coordinator:	Email:	
Phone #:	Fax #:	Employee Hire Date:
Last Day Employee Worked: _____	Donations to Cover: **From:** _____ **Through:** _____	
Donations Received: _____ **Hrs** **(do not exceed hrs needed; can be less not more)**	Hours Needed: _____ **Hrs**	
Is employee on FMLA leave? No ☐ Yes ☐ **If Yes, provide end date of current FMLA**:		
Has the employee been seen by the State Medical Director? No ☐ Yes ☐ **If Yes, provide copy of SMD Report**		
Certified Leave Coordinator's Signature:	**Date:**	

MUST BE COMPLETED BY APPOINTING AUTHORITY/DESIGNEE

As the Appointing Authority/Designee for the employee receiving the leave donation, I certify that this employee has exhausted all forms of annual, sick, personal and compensatory time because of a serious and prolonged medical condition. Approval will not cause the employee to exceed 2,080 hours of leave from the Leave Bank and/or 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 or designee for this employee, I have reviewed the employee's records and I certify that this request meets all of the criteria specified in this Section.**

_____ _____

Signature of Appointing Authority or Designee **Date**

STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

MEDICAL CERTIFICATION FORM (REQUIRED)
TO BE COMPLETED BY TREATING PHYSICIAN

EMPLOYEE'S NAME: _____

PATIENT'S NAME (if not employee): _____

DIAGNOSIS(ES): _____

_____

ICD 10 CODE(S) (Required): _____ _____ _____ _____

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

START DATE OF CURRENT INCAPACITY: _____

SURGERY DATE (IF APPLICABLE): _____

HOSPITALIZATION DATE(S) (IF APPLICABLE): FROM: _____ TO: _____

DATE EMPLOYEE IS LIKELY TO RETURN TO **FULL DUTY** (**REQUIRED**): _____

****

PLEASE COMPLETE THIS SECTION ONLY IF EMPLOYEE CAN RETURN IN A MODIFIED CAPACITY

MODIFIED RETURN DATE (IF APPLICABLE): _____ (**CANNOT BE SAME AS FULL**)

PROVIDE RESTRICTIONS FOR MODIFIED DUTY (**REQUIRED WITH A MODIFIED DATE**):

****

_____ _____

PHYSICIAN'S NAME (PRINT) **PHYSICIAN'S PHONE NUMBER**

_____ _____

PHYSICIAN'S SIGNATURE (WET SIGNATURE) **DATE FORM COMPLETED**

(PLEASE ATTACH REQUIRED MEDICAL VERIFICATION OF SURGERY)

Failure to provide sufficient medical documentation may delay the processing of this request. This information shall be treated as a confidential medical record; it shall not be placed in the employee's personnel file.

STATE EMPLOYEES' LEAVE BANK PROGRAM

AUTHORIZATION FORM TO REVIEW RECORDS AND INFORMATION

A. Identification: This document authorizes the use and/or disclosure of confidential protected health information about the following person: **this is not used to request medical records or information on the employee's behalf.**

Employee's Name: _____ Date of Birth: _____

B. Directions for Release to Review:
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:
- State Medical Director
- State Employees' Leave Bank Program

B.1b. I authorize the release 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) to determine my eligibility for leave from the State Employees' Leave Bank 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: This authorization is required for every request for leave. 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. To revoke the authorization, I must contact, in writing: Yvette Romero, Deputy Director, Personnel Services, Department of Budget and Management at Yvette.romero@maryland.gov .

D. Authorization and Signature: I authorize the **review** 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 understand that electronic signatures are not accepted on this form. 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 **review** and/or disclosure of my confidential protected health information.

_____ _____
Employee Signature Date

STATE EMPLOYEES' LEAVE BANK PROGRAM

MEDICAL DOCUMENTATION LIST

In most situations, your leave request will be evaluated without the benefit of a personal examination. Please have your health care provider(s) submit appropriate medical documentation to support your request (especially for very prolonged absences). The best thing to submit for favorable consideration is medical documentation that **addresses the specific reason for your request and ONLY the period of time for which the leave is requested.**

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, MRI, Myelogram, Angiography, CT Scan, Etc.)
6)	Reports Of X-Rays read by Examining Physician
7)	Physical Therapy Notes ***Note: Leave Bank hours cannot be granted for Physical Therapy unless it is included within the recommended recovery time for the specified medical condition***
8)	Reports from Specialists
9)	Proof of surgery or other Procedure, including employee's name and date of procedure ***Note: If the Medical Certification form (MS 402) provided with the request is dated prior to the surgery, additional documentation confirming surgery must be provided.***