

# 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 Employee <u>Receiving</u> Donations:	<u>Receiving</u> Employee's Agency Name:
Name of <u>Donating</u> Employee*:	SS# of <u>Donating Employee</u> *:
<small>* Your <u>full</u> Name and Social Security Number is <u>required</u> to help verify your identity. Failure to provide it may result in delays and/or rejection of this request. This information is kept confidential in accordance with Federal and State laws and regulations.</small>	
Agency Name:	Agency Code:
<b>TYPE OF LEAVE DONATED:</b>	<b>TOTAL HOURS DONATED:</b>
SICK**	
ANNUAL	
PERSONAL	
I understand that if the employee to whom I am donating leave does not use the leave for any reason, <i>the unused donated leave shall be returned to my leave balances by my Appointing Authority.</i>	
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.)

# 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)

<b>Name*:</b>		<b>SS#*:</b>	
<small>* Your full Name and Social Security Number is <b>required</b> 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 in accordance with Federal and State laws and regulations.</small>			
<b>Job Title <u>and</u> brief description of duties:</b>			
Home Address:		City/State/Zip:	
Agency Name:		Request Type:      New              Extension	
<b>Reason for Request:</b>			
An illness or disability of the employee due to a <i>serious and prolonged medical condition that existed at the time the leave was donated</i> ; <b>or</b>			
A catastrophic illness or injury of a member of the employee's immediate family for whom the employee is needed to provide direct care**.			
<b>**For family member please provide - Name:</b>		<b>Relationship:</b>	
<b>**Describe care to be provided:</b>			
<b>Signature:</b>		<b>Date:</b>	

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

Leave Bank/Donation Coordinator:		Email:	
Phone #:	Fax #:	Employee Hire Date:	
Last Day Employee Worked: _____	Dates to Cover: <b>From:</b> _____ <b>Through:</b> _____		
Donations Received: _____ <b>Hrs</b>	Hours Needed: _____ <b>Hrs</b>		
Is employee on FMLA leave?    No    Yes <b>If Yes, provide <u>end date</u> of <u>current</u> FMLA:</b>			
Has the employee been seen by the State Medical Director?    No    Yes <b>If Yes, provide copy of SMD Report</b>			
<b>Leave Coordinator's Signature:</b>		<b>Date:</b>	

## 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