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 Receiving Donations:	**Receiving Employee's Agency Name:**
Name of **Donating** Employee*:	SS# of **Donating Employee***:

** Your **full** Name and Social Security Number is 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 in accordance with Federal and State laws and regulations.*

Agency Name:	Agency Code:

TYPE OF LEAVE DONATED:	**TOTAL HOURS DONATED:**
[ ] 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.)*

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*:	**SS#*:**
** Your full Name and Social Security Number is **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 in accordance with Federal and State laws and regulations.*	
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:**

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: **From:** _____ **Through:** _____	
Donations Received: _____ **Hrs**	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**		
Leave Coordinator's Signature:	**Date:**	

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**

MS 405
(Rev. 4/2018)