

# STATE EMPLOYEES LEAVE BANK REQUEST FORM

## PART I - TO BE COMPLETED BY EMPLOYEE (PLEASE TYPE OR PRINT)

Name: Title: <input type="checkbox"/> Ms. <input type="checkbox"/> Mr.	Workday#: W	Agency Hire Date:
<i>(Your full Name and Workday Number are <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).</i>		
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:

## PART II - TO BE COMPLETED BY AGENCY HR/LEAVE BANK COORDINATOR

Certified LB Coordinator:		Email:
Phone #:	Full Agency Name:	
Last Date Employee Worked:	Leave Bank Membership Expiration Date:	
Hours Needed (after EE leave is exhausted):	Dates LB will be needed: From:	To:
Can the agency accommodate a modified duty assignment? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Is the employee on FMLA leave? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If yes, provide end date of current FMLA:</b>		
Has the employee been on one-day sick slip restriction within the last two years? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If yes, provide effective date of restriction:</b>		
Has the employee been disciplined within the last year? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If yes, provide effective date of disciplinary action:</b>		
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? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, Contact DBM Leave Bank Program Manager</b>		
Has the employee been seen by State Medical Director? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, Provide copy of Medical Report</b>		
Has the employee applied for Disability Retirement? <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, Provide copy of signed SRA 129</b>		
Certified LB Coordinator's Signature:		Date:

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

## PART III - 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