EMPLOYEE INSTRUCTIONS FOR SUBMITTING A LEAVE BANK REQUEST

This packet contains information, and all forms REQUIRED to request leave from the Leave Bank**.** **Please review the checklist below** to ensure you understand the requirements and that **ALL** required forms are submitted **correctly**:

- ☐ **Fact Sheet for the State Employees' Leave Bank** – Contains general information about joining and applying for leave from the Leave Bank. **Please review.**
- ☐ **State Employees' Leave Bank Request Form (MS-408)** – Please complete Employee Section and submit to your **Agency** Leave Bank Coordinator in your HR Office.
- ☐ **State Employees' Leave Bank Medical Certification Form (MS-402)** – Please have your treating physician(s) complete **ALL** questions and submit to your **Agency** Leave Bank Coordinator with packet. ***If this form has been dated prior to surgery, additional documentation confirming surgery must be provided. For birth of a child, employees should apply for Parental Leave.***
- ☐ **Authorization Form to "Review Records & Information" (HIPAA Form)** – Please complete and submit to your **Agency** Leave Bank Coordinator with packet. ***An electronic signature and date will not be accepted on this form; only the employee's handwritten signature and date will be accepted***.
- ☐ **State Employee's Leave Bank Enrollment Form (MS-401)-**Please include the employee's most recent enrollment form to verify your current LB membership.
- ☐ **Leave Bank – Medical Records/Documentation** – See and review explanation below:

To ensure proper review of your request, adequate medical records should be provided to specifically address and support your leave of absence 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 submit ***actual medical records/documentation*** that ***address the period.*** It is not necessary for your physician to write any additional notes or letters outside of the period that you are requesting leave for.

Review & Submit to your HR Office

You must review and submit **ALL of the above [forms]** to your ***Agency's*** *Leave Bank Coordinator/HR Office*. ***Your Agency will also review to ensure forms are completed correctly and submit the Leave Bank Request to DBM for review and consideration***. A determination will be issued within 30 days of receiving all required forms and any related documents. ***Failure to provide a fully completed and accurate packet may delay the review process.***

STATE EMPLOYEE'S LEAVE BANK – EMPLOYEE FACT SHEET

(PLEASE REVIEW BEFORE SUBMITTING YOUR REQUESTS)

Employees who join the Leave Bank for the very first time **must wait 90 days before requesting leave**. Membership is for a two-year period and may be renewed during Open Enrollment by donating an additional eight hours of leave**. It is the responsibility of each employee to ensure that the Leave Bank Enrollment Form has been received and processed by the Agency Human Resources (HR) Office**. Please check with your HR Office if you have questions about your Leave Bank eligibility or membership.

To request for leave from the Leave Bank, an employee:

- ✓ **must be** an active member of the Leave Bank;
- ✓ **must have** exhausted **all** forms of annual, sick, personal, compensatory and any other leave available at the time of the request; (*requests must be submitted at the time the leave is needed*)
- ✓ **must qualify** for the use of sick leave under the requirements of the employee's personnel system;
- ✓ **must have** a satisfactory performance rating;
- ✓ **must have** a serious **and** prolonged (*continuous*) medical condition; **not for intermittent use**.
- ✓ **must provide** sufficient medical documentation to support the time period being requested in the Leave Bank request; (*in addition to the medical form)*
- ✓ **must be able,** in all likelihood, to return to work;
- ✓ **must not have** already received more than 2,080 hours of leave from the Leave Bank and/or the Employee- to-Employee Leave Donation Programs;
- ✓ **must not have** a record of sick leave abuse (i.e., must not have been on a one-day sick slip restriction within the past two years);
- ✓ **must not have** been disciplined within the past year; and
- ✓ **must not have** used more than 16 continuous months of leave from the Leave Bank and all other forms of paid leave.
- ✓ **Denials** – If denied, employees have 14 days to appeal to correct any deficiencies; any LB being granted will stop and employee will be unpaid pending the appeal review.

To request leave from the Leave Bank, members must **complete and submit** a State Employees' Leave Bank Request Packet and provide medical records that address the absence for which Leave Bank is requested. The most **current** Leave Bank forms must be used. Check with your HR Office or on the DBM website at www.dbm.maryland.gov. Please submit ALL completed forms and medical documentation to your HR Office for review and submission to DBM for consideration. DBM will issue a determination within 30 days of receiving ALL required forms and any related documents. The **Leave Bank Medical Form cannot be substituted** with other medical notes.

If an employee exhausts their accrued leave before DBM makes its determination, the employee shall be granted leave until a decision is rendered **(not to exceed 160)**. If an employee is automatically granted leave and the request is subsequently denied (on appeal), any leave used must be recovered with ½ of the employees accrued sick leave. *At the employee's discretion, additional sick leave and any accrued annual, personal, compensatory or any other available leave may be applied to the reimbursement or the employee may elect to make cash payments*.

Approval to use leave from the Leave Bank is **discretionary** and not based on years of service**.** *Denial may be based on any reason that is consistently applied and is not illegal or unconstitutional.*

STATE EMPLOYEES LEAVE BANK REQUEST FORM

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

Name: **Title:** ☐ **Ms.** ☐ **Mr.**	**Workday#: W**	**Agency Hire Date:**
(Your full Name and Workday Number 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).		
Job Title and brief description of duties (Required):		**State Hire Date:**
Home Address:	**City/State/Zip:**	
Personal Email:	**Request Type:** ☐ **New** ☐ **Extension** ☐ **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? ☐ No ☐ Yes		
Is the employee on FMLA leave? ☐ No ☐ Yes **If yes, provide end date of current FMLA:**		
Has the employee been on one-day sick slip restriction within the last two years? ☐ No ☐ Yes **If yes, provide effective date of restriction:**		
Has the employee been disciplined within the last year? ☐ No ☐ Yes **If yes, provide effective date of disciplinary action:**		
Employee's last performance evaluation rating was: ☐ Satisfactory or Above ☐ Less than Satisfactory		
Is this absence due to an on-the-job injury? ☐ No ☐ Yes **If Yes, Contact DBM Leave Bank Program Manager**		
Has the employee been seen by State Medical Director? ☐ No ☐ Yes **If Yes, Provide copy of Medical Report**		
Has the employee applied for Disability Retirement? ☐ No ☐ Yes **If Yes, Provide copy of signed SRA 129**		
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**

STATE EMPLOYEES' LEAVE BANK PROGRAM

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

PATIENT'S NAME: _____

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 (ONLY IF APPLICABLE): _____
(CANNOT BE THE SAME AS THE FULL DUTY DATE)

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.***

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