EMPLOYEE INSTRUCTIONS FOR SUBMITTING A LEAVE BANK REQUEST

This packet contains information and all forms REQUIRED to request leave from the Leave Bank**.** **Please use the checklist below** to ensure **ALL** required forms are submitted:

- ☐ **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 applicable, proof of surgery or birth MUST be provided. For birth of a child, the type of delivery must be noted on the medical form.***
- ☐ **Authorization Form for Review of Released Records & Information (HIPAA Form)** – Please complete and submit to your **Agency** Leave Bank Coordinator with packet.
- ☐ **Leave Bank – Medical Leave Documentation** – See and review explanation below:

You must submit **ALL of the above forms** to your ***Agency's*** *Leave Bank Coordinator*. ***Your Agency will 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.***

MEDICAL RECORDS/DOCUMENTATION

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 submit ***actual medical records/documentation*** that ***address the period from January 1 to January 15***. It is not necessary for your physician to write any additional notes or letters.

See the attached list of acceptable Medical Documentation.

FACT SHEET FOR THE STATE EMPLOYEE'S LEAVE BANK

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 verify that the Leave Bank membership 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 qualify 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 and compensatory leave;
- ✓ **must qualify** for the use of sick leave under the requirements of the employee's personnel system;
- ✓ **must have** received a satisfactory performance rating;
- ✓ **must have** a serious **and** prolonged medical condition;
- ✓ **must provide** sufficient medical documentation to substantiate absence for the time period covered by the Leave Bank request;
- ✓ **must be able,** in all likelihood, to return to work;
- ✓ **must have** received less 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.

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. Leave Bank forms are available from your HR Office or on the Department of Budget and Management (DBM) website at www.dbm.maryland.gov. Please submit ALL completed forms and medical documentation to your HR Office. The HR Office will review and send the Leave Bank request to DBM for consideration. DBM will issue a determination within 30 days of receiving ALL required forms and any related documents.

If an employee exhausts accrued leave before DBM makes its determination, the employee shall be granted leave until a decision is rendered. If an employee is automatically granted leave and the request is subsequently denied, any leave used must be recovered. The employee shall reimburse the State at a minimum rate of one half of all sick leave earned. *At the employee's discretion, additional sick leave and any accrued annual, personal or compensatory 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.** *Denial may be based on any reason that is consistently applied and is not illegal or unconstitutional.*

STATE EMPLOYEES LEAVE BANK REQUEST FORM

TO BE COMPLETED BY EMPLOYEE *(Please **TYPE or PRINT**)*

Name*:	SS#*:	Hire Date:
** 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:		State Hire Date:
Home Address:	City/State/Zip:	
Full Agency Name:	Request Type: New ☐ Extension ☐ Updated ☐	
Signature:	Date:	

TO BE COMPLETED BY AGENCY HR/LEAVE BANK COORDINATOR

Leave Bank Coordinator:	Email:
Phone #:	Fax #:
Last Date Employee Worked:	Leave Bank Membership Expiration Date**:
Hours Needed: _____ **Hrs**	Dates to Cover: **From** **Through**
Can agency accommodate a modified duty assignment? No ☐ Yes ☐	
Is employee on FMLA leave? No ☐ Yes ☐ **If Yes, provide end date of current FMLA:**	
Has employee been on one-day sick slip restriction within the last two years? No ☐ Yes ☐ **If Yes, provide effective date of restriction:**	
Has 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 the 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**	
Leave Bank Coordinator's Signature:	Date:

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

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 of the criteria specified in this Section.**

_____ _____

Signature of Appointing Authority or Designee **Date**

STATE EMPLOYEES' LEAVE BANK REQUEST

MEDICAL CERTIFICATION FORM

TO BE COMPLETED BY EMPLOYEE'S TREATING PHYSICIAN

PATIENT'S NAME: _____

DIAGNOSIS(ES): _____

_____

ICD 10 CODE(S): _____ _____ _____ _____

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

_____

_____

_____

START DATE OF CURRENT INCAPACITY: _____

SURGERY DATE (IF APPLICABLE): _____

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

CAN EMPLOYEE WORK IN A MODIFIED CAPACITY? YES_____ **NO**_____

IF YES, PROVIDE RESTRICTIONS FOR MODIFIED DUTY:

_____

_____

DATE EMPLOYEE IS LIKELY TO RETURN TO:

MODIFIED DUTY: _____ **FULL DUTY:** _____

_____ _____

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

_____ _____

PHYSICIAN'S SIGNATURE **DATE FORM COMPLETED**

(PLEASE ATTACH MEDICAL VERIFICATION OF SURGERY OR BIRTH – TYPE OF BIRTH IS REQUIRED)

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. Only those individuals with a need to know this information will be given access to it. An employee who fails to appropriately safeguard the confidentiality of this information will be subject to disciplinary action, including termination from State Service.

STATE EMPLOYEES' LEAVE BANK PROGRAM

AUTHORIZATION FORM FOR REVIEW OF RELEASED 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:
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: 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. This authorization will expire one year after the date it is signed. To revoke the authorization, I must contact, in writing: Jennifer Hine, Director, Personnel Services, Department of Budget and Management, 301 W. Preston Street, Room 705, Baltimore, MD 21201 or via Fax at 410-333-5440.

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 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

(Rev. 4/2018)

STATE EMPLOYEES' LEAVE BANK PROGRAM

MEDICAL DOCUMENTATION

In most situations, your leave request will be evaluated without benefit of a personal examination. Please have your health care provider(s) submit appropriate medical documentation to support your request. The best thing to submit for a favorable consideration is medical documentation that **addresses 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, Myelogram, Angiography, Cat Scan, Etc.)
6)	Reports Of X-Rays As Read By Examining Physician
7)	Physical Therapy Notes
8)	Reports from Specialists
9)	Date **and** proof of surgery or other Procedure
10)	For Pregnancy Cases, Expected Due Date **and** Actual Delivery Date, Type of Delivery and Copy of Antepartum Record; a birth certificate is not medical proof for birth.

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