

STATE EMPLOYEES' LEAVE BANK ENROLLMENT FORM

EMPLOYEE TO COMPLETE *(Please TYPE or PRINT)*

Please complete this form if you wish to donate leave to **JOIN (within first 60 days)** or **ENROLL/RENEW (during Open Enrollment)** your membership in the State Employees' Leave Bank.

NAME*: _____ **SS#*:** _____

**You must provide your full Name and Social Security Number to help us verify your identity. Failure to do so may result in rejection of your membership. Your number will be kept confidential in accordance with Federal and State laws and regulations.*

FULL AGENCY NAME: _____ **HIRE DATE:** _____

If you are joining the Leave Bank for the FIRST TIME, you must be a member for at least 90 days before you are eligible to RECEIVE leave.

TYPE OF LEAVE	DONATED HOURS	NEW BALANCE
Personal		
Annual**		
Sick***		

APPLICATION STATUS (√)	
	INITIAL – OPEN ENROLLMENT
	INITIAL – NEW HIRE (First 60 days)
	RENEWAL – OPEN ENROLLMENT
	REHIRE

I hereby certify that I agree to donate eight (8) hours of sick, annual or personal leave, or a combination thereof, to establish membership in the State Employees' Leave Bank Program. *By participating I understand that I will be a member for two (2) years from the effective date of enrollment.*

SIGNATURE OF EMPLOYEE

DATE

** New State of Maryland employees are not eligible to donate Annual Leave until they have at least six months of State Service.

***State of Maryland employees are not eligible to donate Sick Leave unless they will have a balance of at least 240 hours after donation.

APPOINTING AUTHORITY/DESIGNEE TO COMPLETE

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 is subtracted.*

APPOINTING AUTHORITY/DESIGNEE

DATE

**Employee's Membership
will Expire on:**

Hrs of selected Leave were deducted from balance on _____ by _____ / _____
Print / Initial

(Note: Leave must be adjusted within seven (7) days per COMAR 17.04.11.23)

Original to: Employee File

Copy to: Employee (**Certified**)
DBM (leave.bank@maryland.gov or fax to (410) 333-7671)

MS 401 (Rev. 10/2019)