

STATE EMPLOYEES' LEAVE BANK
APPEAL FORM FOR DENIAL OF LEAVE

(ALL FIELDS ARE REQUIRED)

NAME: _____ DATE: _____

HOME ADDRESS: _____

PERSONAL EMAIL: _____

AGENCY NAME: _____ JOB TITLE: _____

My request for leave should be reconsidered because:

In addition to submitting your appeal, please have your treating physician(s) fax any medical records that support your Leave Bank absence. The medical documentation should address only the period of time you need leave from the Leave Bank. It must include detailed information that explains the severity and duration of your medical condition(s). Please refer to the State Employees' Leave Bank – Medical Documentation form you received with your denial letter for examples of the type of documentation that should be provided. The appeal and the records may be faxed to 410-333-5440.

MS 406-LB
Rev. 9/21/20