STATE EMPLOYEES LEAVE BANK REQUEST FORM

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

Name*:	**Workday#: W** _ _ _ _ _ _ _	**Agency Hire Date:** / /
Your full Name and Workday Number (W#) 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:**	

TO BE COMPLETED BY AGENCY HR/LEAVE BANK COORDINATOR

Leave Bank Coordinator:	Email:	
Phone #:	**Full** Agency Name:	
Last Date Employee Worked: / /	Leave Bank Membership Expiration Date**: / /	
Hrs. Needed (after EE leave is exhausted):	**Dates to Cover: From** / / **To:** / /	

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 the criteria specified in this Section.**

_____ _____

Signature of Appointing Authority or Designee **Date**