

State Employees' Leave Bank - Submitting Requests for Leave

This packet contains information and all forms necessary to request leave from the Leave Bank:

1. Fact Sheet for the State Employees' Leave Bank – Contains general information about joining and applying for leave from the Leave Bank
2. State Employees' Leave Bank Request Form (MS-408) – Please complete Section #1 and submit to your Agency Leave Bank Coordinator in the Personnel Office
3. State Employees' Leave Bank Medical Request Form (MS-402) – Please have your treating physician(s) complete and submit to your Agency Leave Bank Coordinator
4. Authorization Form for Release of Records & Information (HIPAA Form) – Please complete and submit to your Agency Leave Bank Coordinator
5. Leave Bank – Medical Leave Documentation – Provides examples of medical records that should be provided by your treating physician(s) to support your request

MEDICAL RECORDS

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

You must submit the State Employees' Leave Bank Request Form (MS-408), the State Employees' Leave Bank Medical Request Form (MS-402) and the Authorization Form for Release of Records & Information (HIPAA Form) to your Agency Leave Bank Coordinator. Your Agency will submit the Leave Bank request to DBM for consideration. A determination will be issued within 30 days of receipt of your request.

You may wish to have your physician submit additional medical records directly to the Department of Budget and Management (DBM). The records may be mailed, faxed or emailed to:

Ms. Lisa Waskiewicz, Leave Bank Coordinator
Department of Budget and Management
301 West Preston Street, Room 602
Baltimore, MD 21201
Phone: 410-767-1697
Secure Fax: 410-333-5440
Email: lisa.waskiewicz@maryland.gov

FACT SHEET FOR THE STATE EMPLOYEES' LEAVE BANK

To join the Leave Bank, employees must donate eight hours of sick, annual or personal leave or a combination thereof. New employees may join within the first 60 days of employment or during open enrollment, which occurs at the same time as the State's health insurance open enrollment. All other employees may join or renew Leave Bank membership during open enrollment. Employees who join the Leave Bank for the very first time must wait 90 days before using leave. Membership is for a two-year period and may be renewed 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 Personnel Office. Please check with your Personnel 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 **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 have received a satisfactory performance rating;
- must **not** have been disciplined within the past year;
- 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 in all likelihood be able to return to work;
- must have received less than 2,080 hours of leave from the Leave Bank and the Employee-to-Employee Leave Donation Programs; 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 a State Employees' Leave Bank Request Form (MS-408). Members must also have their physician complete a State Employees' Leave Bank Medical Request Form (MS-402) and provide medical records that address the absence for which Leave Bank is requested. Leave Bank forms are available from your Personnel Office or on the Department of Budget and Management (DBM) website at www.dbm.maryland.gov. Please submit completed forms and medical documentation to your Personnel Office. The Personnel Office will send the Leave Bank request to DBM for consideration. DBM will issue a determination within 30 days of receipt of the request.

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 converted to leave without pay. 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

SECTION 1 – To Be Completed by Employee

Name:	Classification:
Social Security Number (9 digits): <i>NOTE: Providing your full Social Security Number will help us verify your identity. Failure to provide it may result in rejection of your request. Your number will be kept confidential in accordance with Federal and State laws and regulations.</i>	
Home Address:	City/State/Zip:
Agency:	
Signature:	Date:

SECTION 2 – To Be Completed by Agency Leave Bank Coordinator

Agency Leave Bank Coordinator:	
Phone #:	Fax #:
Last Date Employee Worked:	
Employee needs _____ hours to cover absence from _____	to _____
Can agency accommodate a modified duty assignment? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Is employee on FMLA leave? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide date FMLA entitlement expires: _____	
Has employee been on one-day sick slip restriction within the last two years? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide effective date of restriction: _____	
Has employee been disciplined within the last year? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, provide effective date of disciplinary action: _____	
Employee's last performance evaluation rating was: <input type="checkbox"/> Satisfactory or Above <input type="checkbox"/> Less than Satisfactory	
Is this absence due to an on-the-job injury? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Leave Bank Coordinator's Signature: _____	Date: _____
Agency Recommendation: Approve <input type="checkbox"/> Disapprove <input type="checkbox"/>	

SECTION 3 – To Be 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 Section 3.

Signature of Appointing Authority or Designee

Date

STATE EMPLOYEES' LEAVE BANK
MEDICAL REQUEST FORM

TO BE COMPLETED BY EMPLOYEE'S TREATING PHYSICIAN

PATIENT'S NAME: _____

DIAGNOSIS(ES): _____

ICD-9 CODE(S): _____

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

CPT CODE(S): _____

SURGERY DATE (IF APPLICABLE): _____

HOSPITALIZATION DATE(S) (IF APPLICABLE): From: _____ To: _____

CAN EMPLOYEE WORK IN A MODIFIED CAPACITY? YES _____ NO _____

IF YES, EXPLAIN RESTRICTIONS FOR MODIFIED DUTY:

DATE EMPLOYEE IS LIKELY TO RETURN TO:

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

PHYSICIAN'S SIGNATURE

PHYSICIAN'S NAME (PRINTED)

PHYSICIAN'S PHONE NUMBER

DATE FORM COMPLETED

This document 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 Release of Records and Information

- A. Identification:** This document authorizes the use and/or disclosure of confidential protected health information about the following person:

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 Employees' Leave Bank Program
State Medical Director

B.1b. I authorize the obtaining 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) for employment purposes
- (b) to determine my eligibility for participation in 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 602, Baltimore, MD 21201 or via Fax at 410-333-5440.

- D. Authorization and Signature:** I authorize the release 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 use and/or disclosure of my confidential protected health information.

Your Signature

Signature of Witness

Date

(Revised May 2015)

STATE EMPLOYEES' LEAVE BANK

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 favorable consideration is medical documentation that addresses the period of time you need leave.

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 of Surgery or Other Procedure
10)	For Pregnancy Cases, Anticipated Due Date or Actual Delivery Date, Type of Delivery and Copy of Antepartum Record

(Revised February 2013)