Date Received in OMS ________________

Montgomery County Government & UFCW Local 1994, MCGEO

Sick Leave Bank (SLB) Request Form

To be completed by **employee** or acting on employee's behalf:

Please print

Employee name: ____ Employee ID: _____________

First MI Last

____

Street Address City State Zip Code

DOB: ___________ Primary phone #: _________________ Contact email:_________________________

Your department/division: ____________________ Regular work hours/schedule:________________

Your job title: ________________________ Your supervisor: ___________________________________

Your essential job functions: (☐ check if job description is attached) ____________________________

____

Are you a current member of the SLB? ☐ Yes ☐ No If No, STOP This benefit is <u>only</u> for SLB members.

Have you exhausted all paid leave? ☐ Yes ☐ No If No, STOP You must exhaust all paid leave.

If Yes, Date <u>ALL</u> Leave Exhausted: _________________

Will this leave be: ☐ Block of days ☐ Intermittent

Have you been absent 7 consecutive working days due to this illness/injury? ☐ *Yes ☐ No

*If Yes, Start Date of leave: _________________ Expected End Date: _________________

*If Yes, has a Family and Medical Leave (FMLA) request been completed? ☐ Yes ☐ No

Is this a work related injury/illness? ☐ Yes ☐ No

Has a Workers Comp claim been filed? ☐ Yes ☐ No

I am applying for time to be granted to me from the Sick Leave Bank. Attached is the **SLB Medical Certification** from my healthcare provider. I understand all forms must be completed in its entirety for processing and approval. I have read the policy governing the Sick Leave Bank and understand that:

1. Additional documentation and/or medical consultation may be requested by the OHR Sick Leave Bank administrator at any time during my sick leave.

2. I may not draw on the Sick Leave Bank while also receiving income from Worker's Compensation and/or an employer sponsored disability insurance plan.

3. I understand that the signed and dated healthcare provider's certification **must** include the date that I am out of work and the anticipated date of return.

4. All accrued vacation, personal, sick and compensatory time must be exhausted and I must be absent for 7 consecutive days before being eligible to utilize the SLB.

5. The decision of the SLB Administrator can be appealed. Once an appeal is decided by the MCG/MCGEO Joint Sick Leave Bank Committee the decision is binding and is not subject to grievance appeal procedure.

6. I certify that the information given in this application is correct and complete to the best of my knowledge. I am aware that should an investigation show any material misrepresentation of facts, I will not be considered for SLB benefits. The SLB Administrator and/or the MCG/MCGEO Joint Sick Leave Bank Committee may remove me from the SLB, and I may be subject to disciplinary action up to and including termination.

7. If you received a pay advance, as reflected on your payroll check, those advanced hours will be paid off by your initial grant of donated sick leave. This will cause the payroll check containing the initial grant of donated sick leave to be less than a full check. This Finance Department policy was established to prevent any overpayment of salaries beyond the end of the time sheet certification. The Payroll Section will give you further notice of this adjustment before it sends you the affected payroll check. If you have questions about this, please call the Payroll Section, at 240-777-8840.

8. The Director of the Office of Human Resources may revoke a leave donation to an employee, declare an employee ineligible for leave donations for up to one year, or recommend discipline to the employee's department director, if the employee:

   - Gives false or misleading information on a form associated with the Sick Leave Bank
   - Attempt to use SLB leave for purposes other than its intent

By signing, I am certifying to the above as well as authorizing the healthcare provider and/or the healthcare provider representatives to provide the SLB Administrator, or any of its designees, all information, facts, and particulars which may be requested regarding the physical condition of, or treatment of me. A copy or fax of this form shall have the same effect as the original.

______________________________________ __________________
Employee Signature Date

Montgomery County Government & UFCW Local 1994, MCGEO

Sick Leave Bank (SLB) Request Form

To be completed by employee Department **Supervisor/Manager**

Please Print

Name of employee requesting SLB leave: ______________________________ Department ________________

Please answer each of the questions below.

1. Has the employee had an extended illness or injury, which may include complications of pregnancy or childbirth that causes the employee to be unable to work for 7 consecutive working days or longer?

   ☐Yes ☐No If Yes, Start Date of leave: _________________

2. Has the employee reached County merit status?

   ☐Yes ☐No

If the answer is "no" to either of the questions above, you may ask the Director of the Office of Human Resources and or the SLB joint committee to waive the requirement if special circumstances exist that would justify a waiver.
(See Section SLB Policy and Rules of Procedure for more detail.)

3. Has the employee requested approval to use SLB under the established SLB procedures or practices because of the extended illness or injury referred to in Question #1?

   ☐Yes ☐No

4. Has the employee completed the required Medical Certification Form for SLB leave or a written statement from the employee's health care provider that supports the request for sick leave or PTO donations? (All forms must be submitted to OMS for review and approval.)

   ☐Yes ☐No

5. Has the employee used or will the employee have used all accrued annual leave, sick leave, personal leave days, and compensatory time or, if the employee receives PTO instead of annual and sick leave, all accrued PTO, personal leave days, and compensatory time?

   ☐Yes ☐No If Yes, Date **ALL** Leave was exhausted: __________________

Questions 3-5 above must be answered "yes" in order for the employee to be eligible to receive SLB leave. Questions 1 and 2 must be answered "yes" unless a waiver is approved by the OHR Director and or the SLB joint committee. If the employee has used all of the employee's paid leave and is on **LWOP**, please be sure to notify OHR's Records Management at 240-777-5112.

I certify the information provided in this form is true and accurate to the best of my knowledge at the time of completion.

Name of Department Supervisor/Manager or designee ______________________________________
(Please print)

Signature: ____________________________________ Date:___________________________

Montgomery County Government & UFCW Local 1994, MCGEO

Sick Leave Bank (SLB) Request Form

To be completed by **physician or other licensed health care provider**

Employee/patient's name: _______________________________ Department____________________

The above-named employee/patient is currently under my care. The employee/patient cannot perform the essential functions of the employee/patient's position with the Montgomery County Government because of the employee/patient's serious health condition which may include complications of pregnancy or childbirth.

Is the illness/injury work related? ☐Yes ☐No If surgery, is it elective? ☐Yes ☐No ☐ N/A

Does the patient have an extended illness or injury that causes them to be unable to work for 7 consecutive working days or longer? ☐Yes ☐No *If Yes, Start Date of leave: _____________ Date condition began: ___________

Describe relevant medical facts related to the condition for which the employee seeks leave:

____

____

____

Will this leave be: ☐Block of days ☐Intermittent ☐ Both (If both, fill in a date for each space below)

- If block of days, date employee expected to return to work _________________
- If intermittent, date employee expected to return to full duty _________________

Healthcare provider name: ___________________________ Professional title_________________

Contact phone:___________________ Other phone: _________________

Office address: ____

Street Address City State Zip Code

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINATitle II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information," as defined by GINA, 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.

Certification

I hereby certify that the above information is true and correct. I confirm that I am the treating healthcare provider for the patient above with the injury/illness for which statements above are referenced.

Signature:____ Date:____________________

Submit to: Montgomery County Government OMS/OHR
mcgeoslb@montgomerycountymd.gov
255 Rockville Pike, Suite 125
Rockville, MD 20850
240-777-5137 (office)
240-777-5186 (fax)