



Montgomery County Government & UFCW Local 1994, MCGEO Sick Leave Bank (SLB) Request Checklist

Please read the following information before completing your paperwork:

- ✓ Employee completes pages 1-2.
 - Option 1: Page 1 and 2 are fillable forms that can be completed by typing directly on the forms. After completing pages 1 and 2, print all 4 pages. Employee signs and dates the bottom of page 2.
 - Option 2: Print all 4 pages. Employee completes page 1 and 2 by hand. Be sure to print legibly. Illegible handwriting is the equivalent of missing information and can cause a delay in processing.
- ✓ Employee gives page 3 to their Manager/Supervisor to complete.
- ✓ Employee gives page 4 to their family members Health Care Provider to complete.
- ✓ Once all 4 pages are completely filled out, submit to Occupational Medical Services (OMS) via interoffice mail, fax (240-777-5186), email scan to MCGEOSLB@montgomerycountymd.gov or mail to 255 Rockville Pike, Suite 125, Rockville, MD 20850 Attn: SLB.
- ✓ Please note, there will be a delay in processing your request if there are any missing pages or incomplete information is given. Make sure all forms are completed and submitted in their entirety.



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Sick Leave Bank Request Form – Family Member

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

Please print

Employee name: _____ Employee ID: _____

First MI Last

DOB: _____ Primary contact phone#: _____ Contact email: _____

Your department/division: _____ Regular work hours/schedule: _____

Your job title: _____ Your supervisor: _____

Family Member name: _____ Relationship to employee _____

Are you a current member of the SLB? Yes No If No,  This benefit is only for SLB members.

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

Start Date of leave: _____ End Date: _____

Will this leave be: Block of days Intermittent

Have you been absent 7 consecutive days due to the above family members illness/injury? Yes No

If yes, has a Family and Medical Leave (FMLA) request been completed? 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 FAMILY Member's 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.



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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 investigation show any material misrepresentation of facts, I will not be considered for SLB benefits. The SLB Coordinator 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



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Sick Leave Bank Request Form – Family Member

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

Please Print

Name of employee requesting SLB leave: _____ Department _____

Please answer each of the questions below.

- Has the employee reached County merit status?
Yes No

<p>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.</p>
<p>(See Section SLB Policy and Rules of Procedure for more detail.)</p>

- Has the employee requested approval to use SLB under the established SLB procedures and practices because of the extended illness or injury of a **FAMILY Member**?
Yes No
- Has the employee completed the required Medical Certification Form for SLB leave or a written statement from the employee’s **FAMILY Member** health care provider that supports the request for sick leave or PTO donations? (All forms must be submitted to OHR OMS for review and approval.)
Yes No
- 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

Questions 1-4 above must be answered “yes” in order for the employee to be eligible to receive SLB leave 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: _____



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Sick Leave Bank Request Form – Family Member

To be completed by family members physician or other licensed health care provider

Employee name: _____ Family Member/Patients Name _____

The above-named patient is currently under my care. The patient cannot perform the essential functions of “activities of daily living” (ADLs) or “instrumental activities of daily living” (IADLs) because of the patient’s serious health condition, which may include complications of pregnancy or childbirth, or recovery from childbirth.

Date patients condition began _____

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 schedule _____

If surgery, is it elective? Yes No N/A

Healthcare provider name: _____

Professional title _____
(Medical doctor, licensed physical therapist, etc.)

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 GINA Title 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)