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 3 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 & Family FMLA forms to their family members Health Care Provider to complete.
- ✓ Once all 3 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 27 Courthouse Square, Suite 184, 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.

Date Received in OMS _____

Montgomery County Government & UFCW Local 1994, MCGEO

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, STOP This benefit is only for SLB members.

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

Start Date of leave: _____ End Date: _____

Will this leave be: ☐ Block of days ☐ Intermittent (see SLB policy on intermittent use)

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

***If you are FMLA eligible, an FMLA certification **must** accompany this request.

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.

Montgomery County Government & UFCW Local 1994, MCGEO

Sick Leave Bank Request Form – Family Member

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

Montgomery County Government & UFCW Local 1994, MCGEO

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 "activities of daily living" (ADLs) or "instrumental activities of daily living" (IADLs) without assistance for at least 7 consecutive days because of the patient's serious health condition, which may include complications of pregnancy or childbirth.

Date patients condition began _____ Start Date of Leave Requested: _____

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 _____
  Intermittent time can only be used after 7 consecutive days of absence, for treatment and medical appointments.

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 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
27 Courthouse Square, Suite 184
Rockville, MD 20850
240-777-5137 (office)
240-777-5186 (fax)