# STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

## INSTRUCTIONS FOR SUBMITTING AN EMPLOYEE-TO-EMPLOYEE DONATION LEAVE REQUEST

This packet contains information and all forms necessary to request leave from the Employee-to-Employee Leave Donation Program:

1. Fact Sheet for the Employee-to-Employee Leave Donation Program– Contains general information about donating and receiving leave from the Employee-to-Employee Leave Donation Program.

2. Employee-to-Employee Leave Donation Program - Request Form (MS405) –
   - **Part I** – To be completed by employee **donating** leave and their Agency Appointing Authority
   - **Part II** - To be completed by employee **receiving** leave and their Agency Appointing Authority

3. Employee-to-Employee Leave Donation Program - Medical Certification Form (MS402-EE) – Please have your treating physician(s) complete; submit the medical form with Form MS 405 and the HIPAA form to your HR Office.

4. Authorization Form for Review of Records & Information (HIPAA Form) – Please sign, date and submit, with the MS 402 and MS 405, to your HR Office.

5. Employee-to-Employee Leave Donation Program – Medical Documentation – Provides examples of medical records that should be provided by your treating physician(s) to support only the dates for which you are requesting leave. Have physician provide you with as much additional medical documents as possible for the period of leave that is being requested.

## 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.

***If your request is for surgery, proof of surgery must be provided upon your initial request.***

***If your request is for birth of a child, proof and type of birth (normal or C-section) is required.***

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## FACT SHEET

**FOR EMPLOYEES DONATING LEAVE TO OTHER EMPLOYEES:**

- Employees may voluntarily donate unused annual, sick or personal leave to another employee.
- An employee who donates sick leave to another employee must maintain a sick leave balance of at least 240 hours after the donation is deducted.
- An employee who donates leave shall designate the recipient of the leave.
- If an employee who receives leave does not use all of the donated leave, the remaining hours of leave shall be *restored to the employee(s) who made the donation, by their Appointing Authority (**new**)*.

**To donate leave to another employee**, please complete Part I of the State Employees' Leave Donation Form (MS405) and submit the form to your HR Office. You should also provide a copy of the form to the employee to whom you are making the donation. The form is available from your HR Office or on the Department of Budget and Management website at www.dbm.maryland.gov.

**FOR EMPLOYEES RECEIVING LEAVE FROM OTHER EMPLOYEES:**

To qualify for leave from the Employee-to-Employee Leave Donation Program, an employee must:

- have **exhausted** all available annual, personal, sick and compensatory leave because of:
  1) a personal serious and prolonged medical condition that exists at the time the leave is donated; or
  2) a catastrophic illness or injury of a member of the ***employee's immediate family for whom the employee is needed to provide direct care.*** *Catastrophic illness or injury is defined as a condition that is incapacitating or life threatening as certified by a health care provider*. An employee may use leave from another employee to care for a family member only after obtaining approval from the employee's appointing authority. The appointing authority's approval is **discretionary** and ***denial may be based on any reason which is consistently applied and is not illegal or unconstitutional.***
- qualify for the use of sick leave under the requirements of the employee's personnel system;
- must provide sufficient medical documentation to substantiate absence for the time period covered by the Employee-to-Employee Leave request;
- in all likelihood be able to return to work;
- have received less than 2,080 hours of leave from the Leave Bank and the Employee-to-Employee Leave Donation Programs; and
- **not** have used more than 16 continuous months of leave from the Leave Bank, Employee-to-Employee Leave Donation Program and all other forms of paid leave.

**To request leave from another employee**, please complete Part II of the State Employees' Leave Donation Form (MS405) and submit the form to your HR Office. You must also have the treatment provider complete an Employee-to-Employee Leave Donation Program Medical Certification Form (MS402-EE) and provide medical records that address the absence for which Employee-to-Employee Leave is requested. The forms are available from your HR Office or on the Department of Budget and Management website at www.dbm.maryland.gov. Please submit completed forms and medical documentation to your HR Office.

***(Rev. 4/2018)***

# EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM - REQUEST FORM

## PART I - TO BE COMPLETED BY DONATING EMPLOYEE *(Please **TYPE or PRINT** with black or blue Ink)*

| Name of **Donating** Employee*: | W# of **Donating Employee***: | State Hire Date: |
|---|---|---|
| | | |

** Your **full** Name and Workday Number (W#) are required to help verify your identity. Failure to provide it may result in delays and/or rejection of this request. This information is kept confidential.*

| Donating Employee's Agency Name: | Agency Division: |
|---|---|
| | |

**RECEIVING EMPLOYEE'S INFORMATION:**

| Name of Employee: | Employee's Agency Name: | Employee's W#: |
|---|---|---|
| | | |

| **TYPE OF LEAVE DONATED:** | **TOTAL HOURS DONATED:** | **LEAVE BALANCE AFTER DONATION:** |
|---|---|---|
| [☐] SICK** | | |
| [☐] ANNUAL | | |
| [☐] PERSONAL | | |

I understand that if the employee to whom I am donating leave does not use the leave for any reason, ***the unused donated leave shall be returned to my leave balances by my Appointing Authority.***

| **Signature:** | **Date:** |
|---|---|
| | |

**** If you are donating sick leave, you must maintain a balance of at least 240 hours of sick leave after the donation is deducted.**

## CERTIFICATION OF LEAVE FOR DONATING EMPLOYEE – TO BE COMPLETED BY APPOINTING AUTHORITY/DESIGNEE

☐ ANNUAL/PERSONAL LEAVE CERTIFICATION: I have reviewed this employee's leave balances and affirm that s/he has sufficient annual/personal leave to make this donation.

☐ SICK LEAVE CERTIFICATION: I have reviewed this employee's sick leave balance. **I affirm that s/he will have a sick leave balance of at least 240 hours after this donation.** As the Appointing Authority/Designee for the employee making the above leave donation, I certify this donation is in compliance with COMAR 17.04.11.22 C (3).

_____ _____

APPOINTING AUTHORITY/DESIGNEE DATE

*(Per COMAR 17.04.11.22 C (11) The appointing authority of an employee who donates leave shall adjust the donating employee's leave balance **before** forwarding a copy of the MS 405 form to the receiving employee's appointing authority. **If the receiving employee is denied** the use of donated leave, the receiving employee's appointing authority shall notify the donating employee's appointing authority within 7 days of the denial, and the donating employee's appointing authority **shall restore the leave balance of the donating employee** within 14 days of notification from the receiving employee's appointing authority.)*

*******************NOT VALID WITHOUT TIMEKEEPER CERTIFICATION*******************

☐ ***Hrs of selected LEAVE DONATED were deducted from balance on _____ by _____/_____***

***Print Name! (!Required) / Initials***

# EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM - REQUEST FORM

## PART II - TO BE COMPLETED BY EMPLOYEE RECEIVING LEAVE DONATIONS

*(Please **TYPE or PRINT** with Black or Blue ink)*

| **Name*:** | **Workday #*: W** ___ ___ ___ ___ ___ ___ ___ |
|---|---|
| ** 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. This information is kept confidential.* | |
| **Job Title and brief description of duties**: | |
| Home Address: | City/State/Zip: |
| Agency Name: | Request Type: ☐ New ☐ Extension |
| **Reason for Request:** | |
| ☐ An illness or disability of the employee due to *a serious and prolonged medical condition that existed at the time the leave was donated*; **or** | |
| ☐ A catastrophic illness or injury of a member of the employee's immediate family for whom the employee is needed to provide direct care**. | |
| ****For family member please provide - Name:** | **Relationship:** |
| ****Describe care to be provided:** | |
| **Signature:** | **Date:** |

## MUST BE COMPLETED BY AGENCY LEAVE BANK/DONATION COORDINATOR

| Leave Bank/Donation Coordinator: | | Email: |
|---|---|---|
| Phone #: | Fax #: | Employee Hire Date: |
| Last Day Employee Worked: _____ | Dates to Cover: **From:** _____ | **Through:** _____ |
| Donations Received: _____ **Hrs** | Hours Needed: _____ **Hrs** | |
| Is employee on FMLA leave? No ☐ Yes ☐ **If Yes, provide end date of current FMLA**: | | |
| Has the employee been seen by the State Medical Director? No ☐ Yes ☐ **If Yes, provide copy of SMD Report** | | |
| **Leave Coordinator's Signature:** | **Date:** | |

## MUST BE COMPLETED BY APPOINTING AUTHORITY/DESIGNEE

**As the Appointing Authority/Designee for the employee receiving the leave donation, I certify that this employee has exhausted all forms of annual, sick, personal and compensatory time because of a serious and prolonged medical condition**. Approval will not cause the employee to exceed 2,080 hours of leave from the Leave Bank and/or 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 or designee for this employee, I have reviewed the employee's records and I certify that this request meets all of the criteria specified in this Section.**

_____ _____

**Signature of Appointing Authority or Designee** **Date**

# STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

## MEDICAL CERTIFICATION FORM
***TO BE COMPLETED BY TREATING PHYSICIAN***

EMPLOYEE'S NAME: _____

PATIENT'S NAME (if not employee): _____

DIAGNOSIS(ES): _____

_____

ICD 10 CODE(S) (Required): _____ _____ _____ _____

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

_____

_____

_____

START DATE OF CURRENT INCAPACITY: _____

SURGERY DATE (IF APPLICABLE): _____

HOSPITALIZATION DATE(S) (IF APPLICABLE): FROM: _____ TO: _____

DATE EMPLOYEE IS LIKELY TO RETURN TO **FULL DUTY** (**REQUIRED**): _____

**********

***PLEASE COMPLETE THIS SECTION ONLY IF EMPLOYEE CAN RETURN IN A MODIFIED CAPACITY***

MODIFIED RETURN DATE (IF APPLICABLE): _____

PROVIDE RESTRICTIONS FOR MODIFIED DUTY **(REQUIRED WITH A MODIFIED DATE)**:

_____

_____

**********

_____ _____

**PHYSICIAN'S NAME (PRINT)** **PHYSICIAN'S PHONE NUMBER**

_____ _____

**PHYSICIAN'S SIGNATURE (REQUIRED)** **DATE FORM COMPLETED**

**(PLEASE ATTACH REQUIRED MEDICAL VERIFICATION OF SURGERY)**

**Failure to provide sufficient medical documentation may delay the processing of this request. This information shall be treated as a confidential medical record; it shall not be placed in the employee's personnel file.**

# STATE EMPLOYEE-TO-EMPLOYEE LEAVE DONATION PROGRAM

## 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 a favorable consideration is medical documentation that **addresses ONLY the period of time for which the leave is requested.**

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 **and** proof of surgery or other Procedure |
| 10) | For Pregnancy Cases, Expected Due Date **and Actual Delivery Date, Type of Delivery** and Copy of Antepartum Record; a birth certificate is not medical proof for birth. |

*You must also provide sufficient medical documents to allow your request to be reviewed appropriately if your request is to care for a family member.

***Rev. 2/2018***

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## AUTHORIZATION FORM FOR REVIEW OF RELEASED RECORDS AND INFORMATION

**A. Identification:** This document authorizes the use and/or disclosure of confidential protected health information about the following person; **this document is not used to request additional medical records or information on the patient's behalf.**

Employee's Name: _____ Date of Birth: _____

Patient's Name (if not the employee): _____ 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:**
- ☐ My Appointing Authority or Designee
- ☐ State of Maryland Employee-To-Employee Leave Donation Program

**B.1b. I authorize the release 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) to determine my eligibility for leave from the State of Maryland Employee-To-Employee Leave Donation 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 705, Baltimore, MD 21201 or via Fax at 410-333-5440.

**D. Authorization and Signature:** I authorize the **review** 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 **review** and/or disclosure of my confidential protected health information for determining my eligibility for leave.*

| _____ | _____ | _____ |
|---|---|---|
| Employee Signature | Patient Signature (if not employee) | Date |

***(Rev. 4/2018)***