Date Received in OMS _____

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

To be completed by **employee** or person acting on employee's behalf: (Please Print Clearly)

Employee name: _____ Employee ID: _____
First MI Last

_____
Street Address City State Zip Code

DOB: _____ Primary phone #: _____ Personal email:_____

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

Your job title: _____ Your supervisor: _____

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, STOP You must exhaust all paid leave.

If Yes, Date ALL Leave Exhausted: _____

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

Have you or will you be absent 7 consecutive days due to illness/injury? ☐*Yes ☐No

If, No STOP You must be absent for 7 consecutive days

*** Start Date of leave: _____ Expected End Date: _____ ***

Has a Family and Medical Leave (FMLA) request been completed for this absence? ☐Yes ☐No Date Submitted _____

Note: All members who are FMLA eligible, **must** include their FMLA application with this request before it will be processed.

Is this a work-related injury/illness? ☐ Yes ☐No If Yes, 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 with my Healthcare Provider (HCP) may be required by the OHR Sick Leave Bank Administrator or Employee Medical Examiner (EME) at any time while the I am using Sick Leave Bank hours. The EME may refer an employee to another HCP for an independent medical evaluation as necessary.
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. I also may not use SLB while earning or receiving income from secondary employment.
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. If there is a need for me to be out beyond the initial end date, additional documentation and medical records will be requested to extend your absence. This will include an updated anticipated date of return.
4. If I am requesting Sick Leave Bank for a mental/emotional disability, I must be under the care of a licensed psychiatrist or psychologist and involved in an active treatment plan.

5. SLB may be used intermittently for medically necessary follow-up doctor's appointment resulting from a verified illness or disability. To use SLB intermittently, you must:

   a. Meet the seven (7) consecutive calendar day absence away from work requirement. (See policy)
   b. Exhaust all annual, sick, and comp leave (if FMLA applies, comp leave does not have to be exhausted).
   c. Have prior approved SLB hours in a block of hours for the same medical condition.
   d. Submit medical certification that specifies the frequency, duration, and use of the intermittent SLB hours.

6. 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.

7. 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.

8. 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.

9. 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.

10. 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) Medical Certification

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 medically necessary? ☐Yes ☐No ☐ N/A

Does the patient have an extended illness or injury that causes them to be unable to work for 7 consecutive 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: (required)

_____

_____

_____

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 _____ (date required)
- 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
27 Courthouse Square, Suite 180
Rockville, MD 20850
240-777-5137 (office)
240-777-5186 (fax)

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