

# JUDICIARY LEAVE BANK REQUEST FORM

## Section 1: To be completed by employee

Employee Name: \_\_\_\_\_ CONNECT Employee ID #: \_\_\_\_\_

Work Location: \_\_\_\_\_ Job Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Did you submit an application for Disability Retirement?

Have you used any Leave Bank in the last 12 months?

I hereby request leave from the Judiciary Leave Bank for my serious and prolonged illness that prevents me from performing my duties. I understand that violating this policy may lead to disciplinary action, up to and including termination.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Section 2: To be completed by the Administrative Head

I verify the employee named above:

- successfully completed both six months of service and the initial probation, if required to serve one
- was rated “meets standards” or better on their most recent annual performance evaluation
- received no discipline in the last 12 months
- was not subject to a one-day medical slip requirement in the last 12 months
- is not on a Performance Improvement Plan

Last date worked: \_\_\_\_\_ Is modified duty available? \_\_\_\_\_

Administrative Head Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Section 3: To be completed by Human Resources

I verify the employee named above:

- enrolled in the Judiciary Leave Bank for the appropriate leave year
- satisfied the one-time 90 day waiting period

Leave bank used in last 12 months: \_\_\_\_\_ Leave bank used in career: \_\_\_\_\_

FMLA status: \_\_\_\_\_

Authorized Human Resources Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**JUDICIARY LEAVE BANK MEDICAL CERTIFICATION**

**FORM MUST BE COMPLETED IN ITS ENTIRETY BEFORE REQUEST CAN BE REVIEWED**

**Patient's name:** \_\_\_\_\_

**Anticipated dates employee will be medically unable to work:** \_\_\_\_\_

**Diagnosis(es):(Statement)** \_\_\_\_\_

**ICD codes:** \_\_\_\_\_ **CPT codes:** \_\_\_\_\_

**Summary of treatment and anticipated procedures, including number and frequency of any follow up treatments (attach additional sheets, if necessary):**

**Is this related to a workplace injury:** \_\_\_\_\_

**Anticipated date employee can return to: modified activities/duty** \_\_\_\_\_ **full activities/duty** \_\_\_\_\_

**Please explain restrictions for modified duty, if applicable:** \_\_\_\_\_

**Please describe reduced work schedule, if required:** \_\_\_\_\_

**Provider's signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider's name:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Provider's address:** \_\_\_\_\_

**Note: This document shall be treated as a confidential medical record and not placed in the employee's personnel file.**