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 understand and confirm that I have made every effort to save leave to cover my absence. If it is determined that I, the employee, have purposely exhausted accrued leave prior to the absence, I may be denied leave from the leave bank.

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.

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