Orange County Leave Bank

What is it?

The Employee Leave Bank is a pool of money donated by Orange County employees. The money is collected through donations of personal, term, or old sick leave hours and converted to a dollar amount. The leave bank provides additional leave time for an employee experiencing a catastrophic illness or injury after their own leave balances has been exhausted and they are not eligible for disability benefits. If approved, a recipient may be paid up to 60% of their base salary. A catastrophic illness or injury is defined as:

- A serious illness/injury which could be potentially life threatening and/or life altering, which causes the employee to seek treatment through a hospital, or other recognized medical treatment facility, on an inpatient or outpatient basis.

What restrictions apply?

- A recipient must be employed by Orange County for at least six months prior to the request.
- Leave bank cannot be requested for a workers compensation injury.
- Leave Bank cannot be requested for employees eligible for Long-Term or Short-Term Disability.
- Leave bank time cannot continue after short-term/long-term disability eligibility begins.
- An employee is limited to a maximum of 200 hours per fiscal year.
- Leave bank cannot be used to care for a family member, only for the employee's own illness.
- Leave Bank cannot be used for any cosmetic surgery, unless surgery is a result of an illness, accident, or injury.
- Leave bank cannot be used for any illness, accident, or injury received as a result of self-infliction or as a result of involvement in an illegal activity.

Leave Bank Request for Withdrawal Procedures

- Employee completes Request for Withdrawal Form (if unable to complete for themselves a supervisor may submit initial request). A Request for Withdrawal form can be obtained from the Countyline Intranet, Orange County's Internet, or from your HR Service Center.
- Employee must submit a completed "Attending Physician Statement". This form is highly recommended to ensure all the required information is obtained. In addition to the physician's statement, any surgical reports should be submitted if a surgery has occurred. However, in lieu of the form, a letter from the physician on physician's letterhead is acceptable as long as it contains all the required data including the main points listed below:
    - A full description of illness/injury/symptoms (Also include copies of recent office visit transcribed notes)
    - Prognosis for recovery
    - Current and possible future restrictions that prevent the employee from working
    - Explanation of how the employee is being treated (i.e.: surgical intervention, medications, physical therapy, pain management, etc). Should be as specific as possible!
    - Date of follow-up appointments, if necessary
    - Surgical Report, if appropriate
    - Anticipated Date of Return
- All documents must be submitted to Orange County Human Resources Department, Attn: Leave Bank. We suggest using a sealed confidential envelope to protect your privacy. Our address is:
    - P.O. Box 1393, Orlando, FL 32801 or Fax to 407-836-5369
- Request must be received in HR on or before pay date Friday to be considered for the current pay period. The leave bank committee will meet to review new and renewal requests received by the deadline. All personal information and identifiable data is withheld from the committee's view. The committee's decisions are final and non-negotiable. Employees are notified in writing of the committee's decision.

Leave Bank
Request for Withdrawal

(COMPLETE ALL ITEM-OTHERWISE YOUR REQUEST WILL NOT BE CONSIDERED)

Please provide complete information as requested below. This request must be accompanied by medical documentation from your physician (see page two guidelines). After completion, forward to the Leave Bank Committee, Human Resources Division, Attn: Leave Bank. Fax: 407-836-5369

Forms are due to Human Resources by "Pay Day" Friday in order to be considered by the next pay period.

Name:_____Employee ID#:_____

Home Street Address: _____

City: _____ State: _____ Zip Code: _____

Job Title:_____ Current Hourly Pay Rate:_____

Department: _____ Division: _____

Work Phone: (_____) _____ Home Phone: (_____) _____

Date of Hire: _____ Number of Scheduled Hours **Per Pay Period**: _____

Name of Individual(s) who does your payroll: _____Telephone _____

Are you receiving Worker's Compensation Benefits? ☐ Yes ☐ No

Do you have Short Term Disability Coverage? ☐ Yes ☐ No If Yes, after what waiting period:_____Days
(15-30-60)

Have you applied for Short Term Disability? ☐ Yes ☐ No

When was the last day that you worked? _____

Briefly describe your reason for the request:_____

_____

_____

I understand that the Leave is designed to provide assistance to an employee in the event of a personal catastrophic illness or injury. I understand that this request is subject to review by the Leave Bank Committee and is contingent upon the availability of Leave Bank resources. There is no appeals process. I further understand that this request may be for one pay period only, and if additional time is needed beyond the originally granted time, a renewal form will be required.

All of the above information is true and correct to the best of my knowledge. I understand that putting misleading or untruthful information on this form will render me ineligible for the Leave Bank and may subject me to disciplinary action.

_____ _____

Employee Signature Date

HR USE ONLY: As of: _____ (Date)

Personal Time _____
Term Time _____
Old Sick Time _____
Holiday _____
Floating Holiday _____
Leave Bank _____
Unpaid Time _____

Leave Bank ☐ Approved ☐ Disapproved

STD/LTD Verified: _____ STD Eligible Date: _____

Comments: _____

_____

_____

60% of _____(hours) = _____(Eligible Paid Hours)

Authorized by: _____

ORANGE COUNTY GOVERNMENT FLORIDA

Employee Leave Bank
Attending Physician Statement

To Be Completed By Employee:

Full Name:	Employee ID Number:

To Be Completed By The Attending Physician:

I. Diagnosis

A. Diagnosis:

B. Symptoms:

II. History

A. Date you recommended the patient stop work:

B. When did symptoms appear or accident happen?
MM/DD/YY

C. Has the patient ever had the same or similar condition? If so, please provide specific details:

Yes ❑ No ❑

D. Is this condition related to the patient's employment?
Yes ❑ No ❑

E. Did you complete a worker's compensation claim form?
Yes ❑ No ❑

III. Treatment

A. Date of first visit:

B. Date(s) of subsequent visits:

C. Date of most recent visit:

D. Planned course and duration of treatment (include type of surgery and medications, etc.) - **Specifically describe what is being done for this patient:**

IV. Level of Impairment

A. In a work day given two breaks and a meal break, your patient can:

Please explain any other restrictions in detail:

Lift (in pounds): 1-10 ❑ 11-20 ❑ 21-50 ❑ 51-75 ❑ 76-100 ❑ 100+ ❑

Carry (in pounds): 1-10 ❑ 11-20 ❑ 21-50 ❑ 51-75 ❑ 76-100 ❑ 100+ ❑

Sit _____ hours With position changes _____

Stan _____ hours With position changes _____

Walk _____hours With position changes _____

Alternately sit/stand _____ hours With position changes _____

Bend/Stoop: Never ❑ Occasionally ❑ Frequently ❑

V. Hospitalization (if applicable)

A. Date Admitted:	B. Date Discharged:	C. Reason for admission:

D. Name of Hospital	E. Any compelling details:

Note: If a surgery was performed, please include a copy of the surgical report.

VI. Prognosis

A. Since onset of symptoms, the patient's condition has:	B. When do you anticipate the patient can return to work?
❑ Improved ❑ Not changed ❑ Retrogressed	❑ Date_____ ❑ Unable to determine, follow up on _____ ❑ Never

VII. Physician Information

A. Name of physician completing this form:	B. Phone Number:	C. Address:

D. Speciality:	E. Signature: Date:

Acknowledgement: By signing above, I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief.