

## ORANGE COUNTY LEAVE BANK APPLICATION INSTRUCTIONS

### 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 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 Internet or from your Human Resources 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, Benefits Department. **Submit your request via Box.com at: <https://ocfl.box.com/s/pkygv6lcv8qn58ookdyro3210y8dzic2>**. Contact [Benefits@ocfl.net](mailto:Benefits@ocfl.net) if you need assistance.
- Request must be received by **HR Benefits on or before pay day 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 Calendar  
2025**

<b>Leave Bank Application Deadline</b>	<b>Pay Period Begin</b>	<b>Pay Period End</b>	<b>Paycheck Issue</b>
12/27/2024	12/22/2024	01/04/2025	01/10/2025
01/10/2025	01/05/2025	01/18/2025	01/24/2025
01/24/2025	01/19/2025	02/01/2025	02/07/2025
02/07/2025	02/02/2025	02/15/2025	02/21/2025
02/21/2025	02/16/2025	03/01/2025	03/07/2025
03/07/2025	03/02/2025	03/15/2025	03/21/2025
03/21/2025	03/16/2025	03/29/2025	04/04/2025
04/04/2025	03/30/2025	04/12/2025	04/18/2025
04/18/2025	04/13/2025	04/26/2025	05/02/2025
05/02/2025	04/27/2025	05/10/2025	05/16/2025
05/16/2025	05/11/2025	05/24/2025	05/30/2025
05/30/2025	05/25/2025	06/07/2025	06/13/2025
06/13/2025	06/08/2025	06/21/2025	06/27/2025
06/27/2025	06/22/2025	07/05/2025	07/11/2025
07/11/2025	07/06/2025	07/19/2025	07/25/2025
07/25/2025	07/20/2025	08/02/2025	08/08/2025
08/08/2025	08/03/2025	08/16/2025	08/22/2025
08/22/2025	08/17/2025	08/30/2025	09/05/2025
09/05/2025	08/31/2025	09/13/2025	09/19/2025
09/19/2025	09/14/2025	09/27/2025	10/03/2025
10/03/2025	09/28/2025	10/11/2025	10/17/2025
10/17/2025	10/12/2025	10/25/2025	10/31/2025
10/31/2025	10/26/2025	11/08/2025	11/14/2025
11/14/2025	11/09/2025	11/22/2025	11/26/2025
11/28/2025	11/23/2025	12/06/2025	12/12/2025
12/12/2025	12/07/2025	12/20/2025	12/26/2025



# Leave Bank Request for Withdrawal Form

**COMPLETE ALL ITEMS-OTHERWISE YOUR REQUEST WILL NOT BE CONSIDERED**

Please provide complete information as requested below. This form is for Leave Bank Withdrawals. Upon completion, forward to Human Resources, Benefits Department. Attn: <https://ocfl.box.com/s/pkygv6lcv8qn58ookdyro321oy8dzic2>

Forms are due to Human Resources by "Pay Day" Friday in order to be considered for 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? \_\_\_\_\_

Is there a projected Return to Work Date?  No  Yes – If Yes, When? \_\_\_\_\_

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 attending physician statement 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: \_\_\_\_\_



# 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 \_\_\_\_\_  
Stand \_\_\_\_\_ 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:  
 Improved  Not changed  Retrogressed

B. When do you anticipate the patient can return to work?  
 Date \_\_\_\_\_  Unable to determine, follow up on \_\_\_\_\_  Never

### VII. Physician Information

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

D. Specialty: \_\_\_\_\_ 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.**