



HUMAN RESOURCES DEPARTMENT  
FORT BEND COUNTY, TEXAS

Randi Lintner, PHR  
Director of Human Resources

**MEMORANDUM**

To: Judge KP George  
Commissioner Vincent Morales  
Commissioner Grady Prestage  
Commissioner Andy Meyers  
Commissioner Ken DeMerchant

From: Kim Dzierzanowski  
Human Resources Generalist

Subject: Commissioners Court Agenda Item  
Withdrawal Application, Shared Sick Leave Pool  
For May 11, 2021

Date: May 4, 2021

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As provided by the Fort Bend County Employee Information Manual Section 712, Shared Sick Leave Pool, the administrative committee of the Pool is submitting this request for the Commissioners Court agenda. The committee has reviewed the withdrawal application and finds the employee to be eligible to withdraw hours from the Pool. The committee recommends withdrawal as follows:

Employee of Sheriff's Office, Position # 6501-0124 - 240 hours

Please contact Kim Dzierzanowski at 281-341-8616 if you have any questions.

**SHARED SICK LEAVE POOL WITHDRAWAL REQUEST FORM**

FORM 712W

*This form is to be used by members of the Shared Sick Leave Pool to request a withdrawal from the Pool in accordance with Policy 712. Please provide the information requested below, and return the form to Human Resources by interoffice mail, by fax (281-341-8615), or by email to: Kathy.Novosad@fortbendcountytx.gov.*

Employee Name:  Emp. ID: 

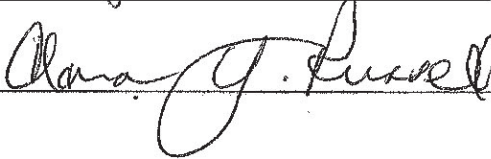
Department/Office: Library - Cinco Ranch Branch

**Shared Sick Leave Pool Administrator:** I am requesting approval to withdraw sick leave from the Shared Sick Leave Pool for the purpose of covering time spent away from work due to my serious medical condition. I understand that I must first exhaust all of my own accrued leave, including sick, vacation, compensatory, and deferred leave prior to withdrawing from the Pool. I also understand that withdrawal from the Pool is subject to limitations and the terms and conditions specified in the *Employee Information Manual, Section 712, Shared Sick Leave Pool.*

I have provided the FMLA form *Certification of Health Care Provider* in support of my request.

Number of hours requested for withdrawal: ~~320~~ 240

Employee Signature:  Date: 4/22/2021

Dept. Head Signature:  Date: 4/26/21

