



# HUMAN RESOURCES DEPARTMENT

FORT BEND COUNTY, TEXAS

Nicole Ledet, PHR  
Director of Human Resources

## MEMORANDUM

To: Judge KP George  
Commissioner Vincent Morales  
Commissioner Grady Prestage  
Commissioner Andy Meyers  
Commissioner Dexter McCoy

From: Tanya Clayton  
HR Administrative Coordinator

Subject: Commissioners Court Agenda Item  
Withdrawal Application, Shared Sick Leave Pool

Date: February 28, 2023

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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:

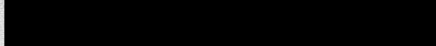
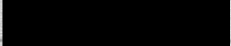
An employee of Constable Precinct #1, Position #5503-0042 – 320 hours

Please contact Tanya Clayton at 281-341-8619 if you have any questions.

**SHARED SICK LEAVE POOL WITHDRAWAL REQUEST FORM**

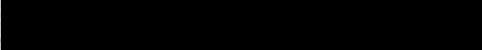

FORM 712W

*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: FBC PCT 1

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: 160Employee Signature:  Date: 2-14-23Dept. Head Signature:  Date: 2-15-23



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Number of hours requested for withdrawal: \_\_\_\_\_

~~0400~~ 160

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

Date: \_\_\_\_\_

1-29-23

Dept. Head Signature: \_\_\_\_\_

Date: \_\_\_\_\_

1-30-23