HUMAN RESOURCES DEPARTMENT
FORT BEND COUNTY, TEXAS

Kent M. Edwards, PHR
Director of Human Resources

To: Judge Robert Hebert
Commissioner Vincent Morales
Commissioner Grady Prestage
Commissioner Andy Meyers
Commissioner James Patterson

From: Kathy Novosad, PHR
Sr. Human Resources Generalist

Date: June 26, 2018

Subject: Revisions to Employee Information Manual: Various Forms

The Human Resources Department is submitting the attached revision to various forms contained in the Employee Information Manual. Both the current forms and the proposed revised forms are attached.

Revision of the forms is needed to add a field for Employee ID. The new forms will be presented in the online Employee Information Manual as fillable PDF forms, which will facilitate easily integrating forms into employee files. All Fort Bend County personnel files are currently being scanned and indexed as part of the Enterprise Content Management initiative, with the goal of eliminating paper and making it easier to file and access documents.

If you have questions, please contact Kathy Novosad at 281-341-8624. The list of revised forms is as follows:

FORM 4A	Resignation statement
FORM 4B	Exit Interview
FORM 6C	Warning Notice
FORM 7C	Request for Leave of Absence
FORM 7D	Notice of Administrative Leave or Suspension Without Pay
FORM 406A	Statement Regarding the Rehire of Former Employee
FORM 413A	Emergency Preparedness Employee Acknowledgement
FORM 413B	Emergency Operations Personnel Waiver Request
FORM 414	Communicable Disease Emergency Temporary Reassignment Request
FORM 615	Request to Establish a Social Media Account or Site for Official County Business Purposes
FORM 704A	Notice of Eligibility and Rights and Responsibilities (FMLA)
FORM 704B	Notice of Leave Designation (FMLA)
FORM 712D	Shared Sick Leave Pool Donation and Enrollment
FORM 712W	Shared Sick Leave Pool Withdrawal Request

FORT BEND COUNTY RESIGNATION STATEMENT

FORM 4A

Use this form to submit a notice of intent to resign from a position with Fort Bend County. Employees are also encouraged to complete an exit interview and survey, on Forms 4B and 4C.

Employee Name _____ Emp. ID _____

Department Name _____ Dept. # _____

Position Title _____

Please accept this document as notification of my intent to resign from the department and position noted above.

My last day of work will be _____

Please provide any comments relevant to your resignation.

Please provide your forwarding address so that tax documents and other correspondence can be sent to you as needed. You may also choose to provide a phone number and personal email.

Forwarding Address

Phone # _____

Personal e-mail _____

Employee Signature _____ Date _____

FORT BEND COUNTY EXIT INTERVIEW

FORM 4B, cont.

Employee Name _____ Emp. ID _____

Employee's Comments

Do you have a new job? ☐ Yes ☐ No

If yes, what is your reason for accepting a new position?

☐ Better Pay ☐ Better Benefits ☐ Opportunity for Advancement

☐ Other _____

Were you dissatisfied with any of the following? (check any that apply)

☐ Supervision ☐ Salary ☐ Benefits ☐ Co-Workers ☐ Job Duties

☐ Opportunity for Advancement ☐ Working Conditions/Equipment

☐ Other _____

Would you like to work for Fort Bend County in the future? ☐ Yes ☐ No

What did you like best about working for the County? _____

What improvements are needed? _____

Other Comments or Suggestions

Supervisor Signature _____ Date _____

Employee Signature _____ Date _____

Supervisor, please complete page 1of this form.

FORT BEND COUNTY EXIT INTERVIEW

FORM 4B

This form is to be completed by the supervisor and employee, if available, on or before the employee's last day of employment with the County.

Department name _____ Dept. # _____

Employee Name _____ Emp. ID _____

Position Title _____ Last Day Worked _____

Reason for Separation ☐ Resigned ☐ Terminated ☐ Retired ☐ End of Assignment

☐ Other _____

Supervisor Name _____

Supervisor's Comments

This employee's work performance:

☐ Exceeded all job requirements ☐ Met all job requirements ☐ Failed to meet job requirements

Would you rehire this employee? ☐ Yes ☐ No

Was attendance satisfactory? ☐ Yes ☐ No

Comments

What were employees strong points? _____

What areas need improvement? _____

Other Comments

Supervisor Signature _____ Date _____

Employee Signature _____ Date _____

Employee, please complete page 2 of this form.

FORT BEND COUNTY WARNING NOTICE

FORM 6C

This document is official record of a warning notice issued and discussed with the employee due to a violation of policy or procedure, and shall be placed in the employee's personnel file.

Employee Name _____ Emp. ID _____

Date Issued _____

Supervisor, check those that apply:

- ☐ Unauthorized absence
- ☐ Failure to call in for absence
- ☐ Tardiness
- ☐ Dress code/uniform violation
- ☐ Fighting, violence, intimidation
- ☐ Harassment
- ☐ Inappropriate/unprofessional conduct
- ☐ Failure to follow orders or carry out duties
- ☐ Theft, distruction, misuse of County property
- ☐ Violation of drug or alcohol policy
- ☐ Falsifying documents, including timesheet
- ☐ Other _____

Supervisor's Comments

Supervisor Signature _____ Date _____

Employee: Your signature below indicates that the above infraction was discussed with you. If you have comments, you may submit them on a separate page.

Employee Signature _____ Date _____

REQUEST FOR LEAVE OF ABSENCE

FORM 7C

Employee Name _____ Emp. ID _____

Date leave to begin _____ Date leave to end _____

Reason for Leave:

(Note that a leave for medical reasons may require Form 7C-Med)

Additional information can be found in the *Employee Information Manual, Policy 706, Leave of Absence*

Employee, please read each item below and the check the box to indicate your understanding.

☐ I understand that failure to return to work on or before the above ending date or failure to request an extension from my Department Head can result in my separation from the County.

☐ I understand it is my responsibility to contact the Risk Management Department for information about maintaining health care coverage during my leave of absence.

☐ I understand that I must exhaust all applicable accrued paid leave before unpaid leave will be granted.

☐ I undersand that I must contact my supervisor the first work day of each week, or on another prearranged schedule, to report my status and intent to return to work.

☐ I understand that I will be required to present a fitness-for-duty certificate prior to being restored to employment if this leave is due to my own serious health condition. If such certification is not received, my return to work may be delayed until certification is provided.

☐ I understand that Fort Bend County does not guarantee that I will be reinstated to my own or any other position in the County. Reinstatement to any position shall be at the discretion of the elected official/department head.

☐ I understand that 6 months is the maximum allowable leave. Commissioners Court approval will be required before any extension can be granted.

_____ _____

Signature of Employee **Date**

To be completed by the Department Head or Elected Official

This is to inform you that your request for a leave of absence is:

☐ Approved, and will be designated as: ☐ Voluntary ☐ Involuntary

☐ Denied for the following reason: _____

_____ _____

Signature of Department Head or Elected Official **Date**

NOTICE OF ADMINISTRATIVE LEAVE OR SUSPENSION WITHOUT PAY

FORM 7D

Employee Name: _____ Emp. ID: _____

Date of Leave: From: _____ To: _____

The above named employee is placed on leave for the dates indicated. The leave is designated as:

☐ **Suspension without Pay for the following reason:**

_____

You may not substitute accrued paid leave for a suspension without pay. If your suspension lasts for one or more full pay periods, you will not accrue any benefits such as vacation or sick leave accruals, or longevity pay, and you may be required to remit payment for your medical benefits. Contact the Risk Management Department for further information regarding benefits. A fitness for duty certificate may be required prior to being restored to employment, depending on the circumstances of the suspension.

☐ **Administrative Leave with Pay for the following reason:**

_____

You will be paid at your regular rate of pay while on Administrative Paid Leave. If your leave lasts for one or more full pay periods, you will not accrue vacation or sick leave or receive longevity payments or supplemental pay such as certification pay. If you are restored to duty, the foregone accruals and payments will be reimbursed to you. If you do not return to duty and your employment is terminated for any reason, you will forego all withheld accruals and payments. Further, your accrued vacation and or comp time will be applied retroactively to the time you were on Administrative Paid Leave.

Additional information can be found in the *Employee Information Manual Policy 707, Administrative Leave and Suspension without Pay*. Your signature below indicates that you have received this notification.

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

STATEMENT REGARDING THE REHIRE OF FORMER EMPLOYEE

FORM 406A

Former Employee Name _____ EMP ID _____

Dept./Office and Job Title of Last Position Held by Former Employee _____

Date of Separation of Employment with FBC _____ Earliest Possible Re-employment Date _____

Dept./Office and Job Title of Position to be Filled _____

Former Employee ☐ Retired ☐ Terminated and withdrew TCDRS account

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TO BE SIGNED BY THE FORMER EMPLOYEE SEEKING REHIRE

By my signature below, I attest that on the date indicated above I completed a bona fide separation of employment with Fort Bend County, meaning that I separated employment without intention to return to work for Fort Bend County after gaining access to my qualified retirement plan with TCDRS. I further attest that NO prior agreement or arrangement, either specified or implied, existed between me and any hiring authority of Fort Bend County to return to any position of employment in Fort Bend County following my separation.

I understand that returning to employment under a specified or implied agreement to return to employment following retirement or access to one's TCDRS account is a violation of federal law (26USC§401(a)), as well as a violation of Texas Government Code Section 842.110. Such violation could result in disqualification of the TCDRS retirement plan and have serious tax consequences for me, as well as all Fort Bend County employees, the County, and all members of TCDRS. I further understand I could be subject to back taxes, penalties and interest and may be required to repay any funds received from my TCDRS account. I further understand that I would be subject to immediate termination of employment which could result in discontinuation of retiree medical benefits provided by Fort Bend County.

Signature _____ Date _____

TO BE SIGNED BY THE DEPARTMENT HEAD OR ELECTED OFFICIAL INITIATING REHIRE

By my signature below I agree that an offer of employment has been made to the individual named above. I understand this individual is a retiree of Fort Bend County, or has otherwise had access to their Fort Bend County TCDRS account, and I attest that to my knowledge, prior to this individual's separation on the date specified above, no agreement, either specified or implied, existed between the individual and Fort Bend County to return to any position of employment with the County. I understand that such an agreement would violate federal law and state statute, and could result in serious tax consequences for all members of TCDRS, including me.

Signature _____ Date _____

TO BE SIGNED BY HUMAN RESOURCES REPRESENTATIVE

The individual named above terminated on _____ and is to be rehired on _____. At least one full calendar month has elapsed since this individual last made a deposit into their TCDRS account. Individual has asserted to me, and I have no reason to believe otherwise, that his/her separation of employment on _____ was a bona fide separation of employment and no prior agreement, either specified or implied, existed between individual and Fort Bend County to return to any position of employment with the County.

Signature _____ Date _____

EMERGENCY PREPAREDNESS EMPLOYEE ACKNOWLEDGEMENT FORM

FORM 413A

Employee Name **Emp. ID#**

Department Name **Dept. #**

Phones – Home **Work** **Cell**

EMERGENCY PERSONNEL DESIGNATION

The Department Head has designated the above named employee as:

☐ **Essential: An employee with specific responsibilities essential to carrying out the emergency plan, and designated to remain in the County on the job or at a designated location during an emergency.**

☐ **Non Essential: Employees whose presence is not essential in carrying out the emergency plan, but who cannot leave their positions until released by their supervisor, and must return to work as usual.**

Department Head and Employee Signatures Required on Page 3

INSTRUCTIONS: READ CAREFULLY THE FOLLOWING STATEMENTS AND INITIAL EACH STATEMENT INDICATING THAT IT HAS BEEN READ AND IS UNDERSTOOD.

_____	**1**	I acknowledge that it is my responsibility to be familiar with the Fort Bend County Emergency Operations Personnel And Pay Procedures and any departmental emergency plans as they apply to me. I understand that a copy of these documents will be made available to me upon request. **I also acknowledge that I have received a copy of Fort Bend County Policy 413, Emergency Operations Personnel And Pay Procedures and Policy 414, Communicable Disease Emergency.**
_____	2	I understand that in the event of an emergency while I am at work, I must remain at work until my direct supervisor or his/her designee releases me. If so released, I understand that I am encouraged to follow instructions as issued by the Fort Bend County Office of Emergency Management.
_____	3	I understand that in the event of an emergency, all employees can be classified as Essential depending on the needs of Fort Bend County; therefore, if I am not at work, it is my responsibility to contact my supervisor, or other designated hotline, regarding assignments. In weather-related events I must stay abreast of the situation by monitoring radio/television/internet for instructions or by calling the Emergency Operations Center or designated hotline for return to duty information.
_____	4	I understand that if I am classified as an "Essential" employee, I must report for work as scheduled or requested. Failure to comply with these requirements may result in disciplinary action up to and including termination in accordance with the Fort Bend County Policy 413, Emergency Operations Personnel And Pay Procedures. I will arrange to have the supplies I need during the emergency when I report to work.
_____	5	I understand that if I am classified as a "Non-Essential" employee, I must report to work immediately following the resumption of normal operations for my next regularly scheduled shift (unless I have prior supervisory approval). Failure to comply with these requirements may result in disciplinary action up to and including termination in accordance with Fort Bend County Policy 413, Emergency Operations Personnel and Pay Procedures.

_____	6	<u>If Classified as Essential:</u> I agree to make the necessary personal phone calls to my family members before coming to my work assignment informing them as to my whereabouts. I understand that a telephone will be available should I need to contact my family members unless the weather disrupts the telephone services to Fort Bend County.
_____	7	I understand that I may be working under emergency conditions for an extended period of time and that I may be assigned 12-hour shifts.
_____	8	**Employees Family:** I understand the importance of making prior arrangements for my family out side Fort Bend County so that at the time of an emergency, I will already know where they will be and who will be taking care of them.
_____	9	I acknowledge that if I am classified as an "Essential" employee during an emergency, food and shelter will be provided for me, and may be provided for my dependents, if necessary. I also understand that my assigned place to sleep may be shared by other employee(s) working on a different shift.

IN SIGNING BELOW, I AM INDICATING THAT I UNDERSTAND, AND FAILURE TO COMPLY WITH THE TERMS STATED IN THIS ACKNOWLEDGEMENT AND ANY FORT BEND COUNTY AND/OR DEPARTMENTAL EMERGENCY PREPAREDNESS PLAN MAY LEAD TO DISCIPLINARY ACTIONS UP TO AND INCLUDING TERMINATION OF MY EMPLOYMENT.

I AM DESIGNATED AS ☐ **ESSENTIAL PERSONNEL** ☐ **NON-ESSENTIAL PERSONNEL**

_____

Employee Printed Name

_____ _____

Employee Signature **Date**

_____ _____

Department Head Signature **Date**

EMERGENCY OPERATIONS PERSONNEL WAIVER REQUEST FORM

FORM 413B

The undersigned employee requests a waiver of his/her designation as an essential employee under Fort Bend County's Emergency Operations Personnel and Pay Procedures Policy for the reasons indicated below.

Employee Name _____ Emp. ID _____

Department Name _____ Dept. # _____

Please describe in full the reason for this waiver request. Relevant documentation may be required.

Employee Phone Numbers Work _____ Cell _____

Employee Signature _____ Date _____

This waiver request is ☐ Approved ☐ Denied

Comments

Supervisor Signature _____ Date _____

COMMUNICABLE DISEASE EMERGENCY
TEMPORARY REASSIGNMENT REQUEST FORM

FORM 414

Employee Name _____ Emp ID _____

Department _____

Cell Phone _____ Home Phone _____

Work Phone _____ Other Phone _____

I am submitting my name in anticipation of being available to work as needed for Fort Bend County in the event of a Communicable Disease Emergency if my department is closed under a Mandatory Protective Closure. As designated non-essential personnel, I understand that such reassignment is non-compulsory and temporary, and may entail duties that are other than my current or usual job responsibilities. I understand that, if temporarily reassigned, I will be compensated for time worked at my regular rate of pay at the time of reassignment, and I will be compensated in accordance with the provisions of the Emergency Operations Personnel and Pay Policy and the Communicable Disease Emergency Policy. I understand that Fort Bend County will take measures to provide a safe and sanitary work environment for all employees who work during a declared Communicable Disease Emergency to the extent possible and in accordance with available guidance from the Centers for Disease Control and Prevention at the time of the emergency.

This form is submitted for purposes of compiling a database of employees interested in Temporary Reassignment, and does not represent a commitment or contract on the part of either Fort Bend County or myself.

Employee Signature _____

Date _____

REQUEST TO ESTABLISH A SOCIAL MEDIA ACCOUNT OR SITE FOR OFFICIAL COUNTY BUSINESS PURPOSES

FORM 615

Date of Request: _____

Department or Office Name: _____

Describe the type of social media you wish to utilize: _____

Please provide a brief statement for the following questions, attaching a separate sheet if necessary

1. What business purpose or need will be served by the use of social media?

2. In what way will social media address this business need or purpose, and what other benefits may be derived from social media use?

3. How will it be determined that the expected results and benefits are achieved?

What time and resources will be required to create and maintain the social media activity?

Who will be permitted to post, comment, administer or otherwise maintain the social media site?

A custodian must be designated for all official Fort Bend County social media accounts or sites. The custodian will, at a minimum:

1. Monitor the site to ensure all posted content is current, accurate and an appropriate representation of Fort Bend County
2. Immediately remove any inappropriate content
3. Ensure compliance with privacy and copyright laws

The custodian for this social media account or site will be:

Name: _____ Title: _____

E-mail: _____ Phone: _____

Note: The Department Head or Elected Official is responsible to ensure the site or account is properly maintained and continues to serve a business purpose

Please circulate this form to the following officials for review and signature:

Department Head or Elected Official: _____

Director of Information Technology: _____

County Judges Office, Public Information Officer: _____

NOTIFICATION OF ELIGIBILITY AND RIGHTS AND RESPONSIBILITIES
FAMILY AND MEDICAL LEAVE ACT
FORM 704A

Employee Name _____ Emp. ID _____

Date _____

You have requested, or otherwise provdied notice, that you may need a leave of absence under the Family and Medical Leave Act for the following reason:

- ☐ The birth of a child or acceptance of a child for adoption or foster care
- ☐ Your own serious health condition, including pregnancy
- ☐ To care for a family member with a serious health condition (name and relationship: _____)
- ☐ A qualifying exigency for a family member in the United States Armed Forces who is called to Active Duty
- ☐ To care for a family member or next of kin with a serious injury or illness incurred in the line of duty while on active duty in the United States Armed Forces (Military Caregiver Leave)

You have indicated your leave will begin or or about _____

The purpose of this notice is to inform you:
- ☐ You are eligible for FMLA leave
- ☐ You are not eligible for FMLA leave at this time because:
  - ☐ You have not worked for Fort Bend County for at least 12 months
  - ☐ You have not worked at least 1,250 hours in the preceding 12 months, or
  - ☐ You have already exhausted your FMLA leave entitlement

If you are eligible for FMLA leave, please note that your FMLA leave may not be approved. You must return a properly completed certification form within 15 days from receipt of the form. Failure to provide certification as requested may result in denial of leave.

If your leave is approved as FMLA leave, the Following Rights and Responsibilities will apply:

1. Eligible employees are entitled to a total of 12 weeks of FMLA leave in a 12 month period (26 weeks for Military Caregiver Leave). The 12 month period is calculated on a rolling 12 month basis measured backward from the date of any FMLA leave usage.
2. Employees on FMLA are entitled to continue medical benefits, subject to the same costs and requirements as other employees not on leave. You must continue to pay your share of the premiums, and payment must be coordinated with the Risk Management Department. Under certain circumstances, if you do not return to employment following FMLA leave, you may be required to reimburse Fort Bend County for the County's share of any costs paid on your behalf during your FMLA leave.
3. You are entitled to reinstatement to the same or equivalent position at the same pay, benefits, and terms and conditions of employment if your leave does not extend beyond the FMLA entitlement and you comply with your responsibilities of leave.
4. You are required to contact your supervisor on the first workday of each week or other prearranged schedule to inform them of your status and intent to return to work.
5. You are required to use any accrued paid leave, including sick, vacation, compensatory and deferred time while you are on leave.. If all paid leave is exhausted, the remaining leave will be without pay.
6. While on unpaid leave, you will not accrue any benefits such as vacation or sick leave, nor will you receive longevity payments.
7. You must provide re-certification of the need for leave if an extension to your original request is needed or the circumstances of your leave change significantly.
8. If the leave is due to your own serious illness or injury, you will be required to furnish certification from your medical provider that you are able to perform the essential functions of your position before returning to work. A job description was provided to you with the medical certification form.

_____

Signature of Department Head or Elected Official

Questions regarding FMLA can be addressd with Human Resources at 281-341-8624

NOTICE OF LEAVE DESIGNATION: FAMILY AND MEDICAL LEAVE ACT

FORM 704B

Employee Name _____ Emp. ID _____

Date _____

This notice is to inform you that your request for FMLA leave is:

☐ Not Approved for the following reason: _____

☐ Approved. All leave taken for this reason will be designated as FMLA leave. Given the information you have provided, we anticipate that the amount of leave needed will be: _____

If the above space is blank, it means we are unable to discern how much leave is needed. You have the right to request a report of hours designated as FMLA every 30 days if desired.

Please Note the Following Rights and Responsibilities:

1. Eligible employees are entitled to a total of 12 weeks of FMLA leave in a 12 month period (26 weeks for Military Caregiver Leave). The 12 month period is calculated on a rolling 12 month basis measured backward from the date of any FMLA leave usage.

2. Employees on FMLA are entitled to continue medical benefits, subject to the same costs and requirements as other employees not on leave. You must continue to pay your share of the premiums, and payment must be coordinated with the Risk Management Department. Under certain circumstances, if you do not return to employment following FMLA leave, you may be required to reimburse Fort Bend County for the County's share of any costs paid on your behalf during your FMLA leave.

3. You are entitled to reinstatement to the same or equivalent position at the same pay, benefits, and terms and conditions of employment if your leave does not extend beyond the FMLA entitlement and you comply with your responsibilities of leave.

4. You are required to contact your supervisor on the first workday of each week or other prearranged schedule to inform them of your status and intent to return to work.

5. You are required to use any accrued paid leave, including sick, vacation, compensatory and deferred time while you are on leave. If all paid leave is exhausted, the remaining leave will be without pay.

6. While on unpaid leave, you will not accrue any benefits such as vacation or sick leave, nor will you receive longevity payments.

7. You must provide re-certification of the need for leave if an extension to your original request is needed or the circumstances of your leave change significantly.

8. If the leave is due to your own serious illness or injury, you will be required to furnish certification from your medical provider that you are able to perform the essential functions of your position before returning to work. A job description was provided to you with the medical certification form.

Questions regarding FMLA can be directed to Human Resources at 281-341-8624

☐ **Employees on Worker's Compensation Leave: This notice is to inform you that leave taken due to your workers comp qualifying injury or illness will also be designated as FMLA leave. This designation will in no way affect your workers compensation benefits.**

_____ _____

Signature of Department Head or Elected Offical **Date**

SHARED SICK LEAVE POOL DONATION AND ENROLLMENT FORM

FORM 712D

This form is to be used to enroll in the Fort Bend County Shared Sick Leave Pool or to make an enrichment donation to the Pool, in accordance with Policy 712. Please provide the requested information below, and return the completed form to Human Resources by interoffice mail, fax (281-341-8615), or e-mail to Kathy.Novosad@fortbendcountytx.gov.

Employee Name _____ Emp.ID _____

Department/Office _____

Shared Sick Leave Pool Administrator: Please accept this document as authorization to deduct hours from my accrued sick leave balance, to be credited to the Fort Bend County Shared Sick Leave Pool.

I am donating _____ hours to the Pool:

☐ Self enroll in the Pool. (8 hours minimum, 40 maximum)

☐ Pool enrichment donation. I am already a Pool member. (40 hours maximum)

☐ I am terminating employment or retiring from Fort Bend County, and wish to donate a portion of my unused sick leave to the Pool. (80 hours maximum)

☐ Contribute to the enrollment of another qualifying employee who has worked for the County at least 12 months and has a sick leave accrual balance of 40 hours or more. (A combined **40 hours minimum** must be donated on behalf of this employee by one or more employees.)

Name of employee to be enrolled: _____

I have read and understand the Employee Information Manual, *Section 712, Shared Sick Leave Pool.* I agree to abide by all the rights and responsibiities detailed in the policy.

Signature of Employee: _____

Date: _____

For questions regarding the Shared Sick Leave Pool, please contact Kathy Novosad in Human Resources at 281-341-8624.

SHARED SICK LEAVE POOL WITHDRAWAL REQUEST FORM

FORM 712W

This form is to 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: _____

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: _____

Employee Signature: _____ Date: _____

Dept. Head Signature: _____ Date: _____

For Pool Administrator Use Only

Self-enrolled or EBO _____

Position # _____

Date Began FMLA _____

Member Since _____

Length of Service _____

Sick Leave Used _____

Vacation Used _____

Comp/Other Used _____

Previous Pool Withdrawal _____

FORT BEND COUNTY RESIGNATION STATEMENT

I, _____, hereby resign my position as _____, effective _____ (date).

The reason for my resignation is as follows: _____

_____

My forwarding address is: _____

_____

I plan to begin working for the following employer: _____

_____

If not starting a new job, I do ____ do not ____ plan to seek other employment.

Additional Comments: _____

_____

Signature: _____

Name (please print): _____

Date: _____

Department: _____

Policy Approved and Adopted By:
Fort Bend County Commissioners Court
Form 4A Approved: November 10, 1998
Revised: September 30, 2003

FORT BEND COUNTY EXIT INTERVIEW

Name: _____ Date:_____

Forwarding address: _____

Department: _____ Supervisor: _____

Supervisor's Remarks:

Work Performance: (please check one)

_____Consistently and clearly exceeded all job requirements and responsibilities

_____Frequently exceeded most job requirements and responsibilities

_____Met all job requirements and expectations

_____Demonstrated effort toward meeting minimum standards of job requirements

_____Failed to meet minimum standards for job requirements

Quality of Work:___Outstanding _____Satisfactory _____Unsatisfactory

Did this employee present any supervisory problems? _____

_____

How did this employee get along with others? _____

Would this employee be put back in the same job? _____

Why? _____

Was attendance satisfactory? _____

What were this employee's strong points? _____

What were this employee's weak points? _____

Should Fort Bend County consider this employee for re-employment? _____

_____ _____

Signature of Supervisor Date Signature of Employee Date

_____ _____

Signature of Official/Dept. Head Date Reviewed by HR Rep Date

FORT BEND COUNTY EXIT INTERVIEW (continued)

Do you have a new job? _____ Where?_____

Will you have a better opportunity? _____At what salary? _____

What is your reason for leaving? _____

_____

Were you dissatisfied with any of the following: (please answer **yes** or **no**)

_____Supervision _____Working Conditions

_____Job Responsibilities _____Promotional Opportunities

_____Employee Benefits _____Fellow Employees

_____Salary _____Other: _____

What did you like best about working at Fort Bend County? _____

How did you feel about your supervision? _____

How do you rate the morale in the department? _____

Would you like to work here again? _____

Do you have any suggestions for improving the job or other aspects of the department or division? _____

Other comments: _____

Signature of Supervisor	**Date**	**Signature of Employee**	**Date**
Signature of Official/Dept. Head	**Date**	**Reviewed by HR Rep**	**Date**

Policy Approved and Adopted By:
Fort Bend County Commissioners Court
November 24, 1998
Revised: September 30, 2003

FORT BEND COUNTY WARNING NOTICE

The following warning was issued today and it is to be made a part of the official record:

_____ _____
Name Date

1. ( ) Unreported Absence
2. ( ) Tardiness
3. ( ) Drinking on duty
4. ( ) Insubordination
5. ( ) Failure to obey orders
6. ( ) Fighting with anyone on County Property
7. ( ) Leaving without permission
8. ( ) Improper Conduct
9. ( ) Reporting under the influence of alcohol
10. ( ) Violation of rules
11. ( ) Failure to carry out assigned duties
12. ( ) Destruction or abuse of County Property
13. ( ) Inappropriate dress
14. ( ) Failure to report while off with workers compensation injury
15. ( ) Other_____

REMARKS:

_____

_____

_____

_____

If necessary, use reverse side…

_____
Signature of Supervisor

I have read this report: _____
Signature of Employee

Policy Approved And Adopted By:
Fort Bend County Commissioners Court
July 20, 1993
Revised: September 30, 2003

Fort Bend County Request for Leave of Absence

(To be completed by Employee)

I, _____, request a leave of absence beginning _____ (date) and ending on _____ (date), for the following reasons:

_____

_____

_____

Please Initial and Sign below to indicate your understanding of this policy:

___ I understand that failure to return to work on or before the above ending date or failure to request an extension from my Department Head can result in my separation from the County.

___ I understand it is my responsibility to contact the Risk Management Department for information about maintaining health care coverage during my leave of absence.

___ I understand that I must exhaust all applicable accrued paid leave before unpaid leave will be granted.

___ I understand that I must contact my supervisor the first work day of each week, or on another prearranged schedule, to report my status and intent to return to work.

___ I understand that I will be required to present a fitness-for-duty certificate prior to being restored to employment if this leave is due to my own serious health condition. If such certification is not received, my return to work may be delayed until certification is provided.

___ I understand that Fort Bend County does not guarantee that I will be reinstated to my own or any other position in the County. Reinstatement to any position shall be at the discretion of the elected official/department head.

_____ _____

(Signature of Employee) (Date)

(To be completed by Department Head or Elected Official, and copy given to Employee)

This is to inform you that:

□ **Your request for a leave of absence is approved. This leave shall be designated**

(circle one)

Voluntary Leave of Absence **Involuntary Leave of Absence**

□ **Your request for a leave of absence is denied**

Reason for denial of leave:

_____

_____

_____ _____

(Signature of Dept. Head/Elected Official) (Date)

FORT BEND COUNTY ADMINISTRATIVE LEAVE AND SUSPENSION WITHOUT PAY NOTICE

(To be completed by Supervisor, copy given to Employee)

_____(employee name) has been placed on a administrative Leave or Suspension Without Pay (choose one) for the following reason:

_____

_____.

You will return to work on:_____(date, if known).
Fort Bend County policy does not allow you to substitute accrued paid leave for a Suspension Without Pay.

You may be required to present a fitness-for-duty certificate prior to being restored to employment. Your return to work may be delayed until certification is provided. Please specify below if certification is required:

For a Suspension Without Pay exceeding ten (10) working days, you may elect to continue health benefits at the cost of full premium. You have hereby been informed that arrangements for payments should be made with Risk Management; otherwise coverage may be cancelled.

While on Suspension Without Pay exceeding ten (10) working days, you will not accrue any benefits such as vacation, sick leave or "credited service" for retirement and longevity purposes.

_____ _____
Signature of Elected Official or Department Head **Date**

(To be completed by Employee)

I understand the conditions stated above as they pertain to Administrative Leave or Suspension Without Pay.

I understand that my failure to return to work on the above date, as specified, can result in my separation from the County.

I also understand that Fort Bend County cannot guarantee the availability of my job if it is necessary to fill the job or the job is eliminated due to a reduction-in-force, prior to my return from Administrative Leave or Suspension Without Pay.

I have read this notice:

_____ _____
Signature of Employee **Date**

Form 7D Revised February 10, 2004

STATEMENT REGARDING THE REHIRE OF FORMER EMPLOYEE

Former Employee Name _____

Dept./Office and Job Title of Last Position Held by Former Employee _____

Date of Separation of Employment with FBC _____ Earliest Possible Re-employment Date _____

Dept./Office and Job Title of Position to be Filled _____

Former Employee ☐ Retired ☐ Terminated and withdrew TCDRS account

---

TO BE SIGNED BY THE FORMER EMPLOYEE SEEKING REHIRE

By my signature below, I attest that on the date indicated above I completed a bona fide separation of employment with Fort Bend County, meaning that I separated employment without intention to return to work for Fort Bend County after gaining access to my qualified retirement plan with TCDRS. I further attest that NO prior agreement or arrangement, either specified or implied, existed between me and any hiring authority of Fort Bend County to return to any position of employment in Fort Bend County following my separation.

I understand that returning to employment under a specified or implied agreement to return to employment following retirement or access to one's TCDRS account is a violation of federal law (26USC§401(a)), as well as a violation of Texas Government Code Section 842.110. Such violation could result in disqualification of the TCDRS retirement plan and have serious tax consequences for me, as well as all Fort Bend County employees, the County, and all members of TCDRS. I further understand I could be subject to back taxes, penalties and interest and may be required to repay any funds received from my TCDRS account. I further understand that I would be subject to immediate termination of employment which could result in discontinuation of retiree medical benefits provided by Fort Bend County.

Signature _____ Date _____

TO BE SIGNED BY THE DEPARTMENT HEAD OR ELECTED OFFICIAL INITIATING REHIRE

By my signature below I agree that an offer of employment has been made to the individual named above. I understand this individual is a retiree of Fort Bend County, or has otherwise had access to their Fort Bend County TCDRS account, and I attest that to my knowledge, prior to this individual's separation on the date specified above, no agreement, either specified or implied, existed between the individual and Fort Bend County to return to any position of employment with the County. I understand that such an agreement would violate federal law and state statute, and could result in serious tax consequences for all members of TCDRS, including me.

Signature _____ Date _____

TO BE SIGNED BY HUMAN RESOURCES REPRESENTATIVE

The individual named above terminated on _____ and is to be rehired on _____. At least one full calendar month has elapsed since this individual last made a deposit into their TCDRS account. Individual has asserted to me, and I have no reason to believe otherwise, that his/her separation of employment on _____ was a bona fide separation of employment and no prior agreement, either specified or implied, existed between individual and Fort Bend County to return to any position of employment with the County.

Signature _____ Date _____

EMERGENCY PREPAREDNESS EMPLOYEE ACKNOWLEDGEMENT FORM

Date Submitted: _____ **Dept Number:** _____

Employee Name: _____ **Title:** _____

Telephone Numbers: **Home:** _____ **Work:** _____

Cell: _____ **Alt:** _____

EMERGENCY PERSONNEL DESIGNATION:

Essential Non Essential

THE FOLLOWING ARE DEFINITIONS OF ALL EMPLOYEE EMERGENCY CLASSIFICATIONS. ONCE THIS FORM IS COMPLETED BY YOU AND REVIEWED BY YOUR DEPARTMENT HEAD, A CLASSIFICATION WILL BE ASSIGNED.

Essential: Employees with specific responsibilities who are designated to remain in the County on the job or at a designated location during an emergency.

Non-Essential: Employees whose presence is not essential in carrying out the emergency plan, but who cannot leave their positions until released by their supervisor, and must return to work as usual.

INSTRUCTIONS: READ CAREFULLY THE FOLLOWING STATEMENTS AND INITIAL EACH STATEMENT INDICATING THAT IT HAS BEEN READ AND IS UNDERSTOOD.

_____ 1 I acknowledge that it is my responsibility to be familiar with the Fort Bend County Emergency Operations Personnel And Pay Procedures and any departmental emergency plans as they apply to me. I understand that a copy of these documents will be made available to me upon request. I also acknowledge that I have received a copy of Fort Bend County Policy 413, Emergency Operations Personnel And Pay Procedures.

_____ 2 I understand that in the event of an emergency while I am at work, I must remain at work until my direct supervisor or his/her designee releases me. If so released, I understand that I am encouraged to follow instructions as issued by the Fort Bend County Office of Emergency Management.

_____ 3 I understand that in the event of an emergency, all employees can be classified as Essential depending on the needs of Fort Bend County; therefore, if I am not at work, it is my responsibility to contact my supervisor, or other designated hotline, regarding assignments. In weather-related events I must stay abreast of the situation by monitoring radio/television/internet for instructions or by calling the Emergency Operations Center or designated hotline for return to duty information.

_____ 4 I understand that if I am classified as an "Essential" employee, I must report for work as scheduled or requested. Failure to comply with these requirements may result in disciplinary action up to and including termination in accordance with the Fort Bend County Policy 413, Emergency Operations Personnel And Pay Procedures. I will arrange to have the supplies I need during the emergency when I report to work.

_____ 5 I understand that if I am classified as a "Non-Essential" employee, I must report to work immediately following the resumption of normal operations for my next regularly scheduled shift (unless I have prior supervisory approval). Failure to comply with these requirements may result in disciplinary action up to and including termination in accordance with Fort Bend County Policy 413, Emergency Operations Personnel and Pay Procedures.

If Classified as Essential:

_____ 6 I agree to make the necessary personal phone calls to my family members before coming to my work assignment informing them as to my whereabouts. I understand that a telephone will be available should I need to contact my family members unless the weather disrupts the telephone services to Fort Bend County.

_____ 7 I understand that I may be working under emergency conditions for an extended period of time and that I may be assigned 12-hour shifts.

Employees Family:

_____ 8 I understand the importance of making prior arrangements for my family out side Fort Bend County so that at the time of an emergency, I will already know where they will be and who will be taking care of them.

_____ 9 I acknowledge that if I am classified as an "Essential" employee during an emergency, food and shelter will be provided for me, and may be provided for my dependents, if necessary. I also understand that my assigned place to sleep may be shared by other employee(s) working on a different shift.

IN SIGNING BELOW, I AM INDICATING THAT I UNDERSTAND, AND FAILURE TO COMPLY WITH THE TERMS STATED IN THIS ACKNOWLEDGEMENT AND ANY FORT BEND COUNTY AND/OR DEPARTMENTAL EMERGENCY PREPAREDNESS PLAN MAY LEAD TO DISCIPLINARY ACTIONS UP TO AND INCLUDING TERMINATION OF MY EMPLOYMENT.

_____ _____

Employee Printed Name
Employee Signature Date

_____

Department Head Signature Date

Emergency Operations Personnel Waiver Request Form

The undersigned employee requests a waiver of his/her designation as an essential employee under Fort Bend County's Emergency Operations Personnel and Pay Procedures Policy for the reasons indicated.

Date Submitted: _____ Dept Number: _____

Employee Name: _____ Dept. Name: _____

Telephone Numbers: Home: _____ Work: _____

Cell: _____ Alt: _____

Describe, in full, your reason for this request for waiver of your designation as Essential: (**must include relevant documentation**)

_____

_____

_____

_____

_____

_____ _____

Employee Printed Name Employee Signature Date

_____

Department Head Signature Date Approved Denied

Basis for Denial:

☐ Lacks relevant documentation

☐ Other:

COMMUNICABLE DISEASE EMERGENCY
TEMPORARY REASSIGNMENT REQUEST FORM

Employee Name:_____ **Dept. Number:**_____

Date Submitted: _____**Department**:_____

Telephone Numbers: Work: _____

Home: _____

Cell: _____

Alternate: _____

I am submitting my name in anticipation of being available to work as needed for Fort Bend County in the event of a Communicable Disease Emergency if my department is closed under a Mandatory Protective Closure. As designated non-essential personnel, I understand that such reassignment is non-compulsory and temporary, and may entail duties that are other than my current or usual job responsibilities. I understand that, if temporarily reassigned, I will be compensated for time worked at my regular rate of pay at the time of reassignment, and I will be compensated in accordance with the provisions of the Emergency Operations Personnel and Pay Policy and the Communicable Disease Emergency Policy. I understand that Fort Bend County will take measures to provide a safe and sanitary work environment for all employees who work during a declared Communicable Disease Emergency to the extent possible and in accordance with available guidance from the Centers for Disease Control and Prevention at the time of the emergency.

This form is submitted for purposes of compiling a database of employees interested in Temporary Reassignment, and does not represent a commitment or contract on the part of either Fort Bend County or myself.

Signed: _____**Date:**_____

REQUEST TO ESTABLISH A SOCIAL MEDIA ACCOUNT OR SITE FOR OFFICIAL COUNTY BUSINESS PURPOSES

Date of Request: _____

Department or Office Name: _____

Describe the type of social media you wish to utilize: _____

Please provide a brief statement for the following questions, attaching a separate sheet if necessary

1. What business purpose or need will be served by the use of social media?

2. In what way will social media address this business need or purpose, and what other benefits may be derived from social media use?

3. How will it be determined that the expected results and benefits are achieved?

What time and resources will be required to create and maintain the social media activity?

Who will be permitted to post, comment, administer or otherwise maintain the social media site?

A custodian must be designated for all official Fort Bend County social media accounts or sites. The custodian will, at a minimum:

1. Monitor the site to ensure all posted content is current, accurate and an appropriate representation of Fort Bend County
2. Immediately remove any inappropriate content
3. Ensure compliance with privacy and copyright laws

The custodian for this social media account or site will be:

Name: _____ Title: _____

E-mail: _____ Phone: _____

Note: The Department Head or Elected Official is responsible to ensure the site or account is properly maintained and continues to serve a business purpose

Please circulate this form to the following officials for review and signature:

Department Head or Elected Official: _____

Director of Information Technology: _____

County Judges Office, Public Information Officer: _____

NOTIFICATION OF ELIGIBILITY AND RIGHTS AND RESPONSIBILITIES: FAMILY AND MEDICAL LEAVE ACT

TO: _____ (Employee Requesting Leave)

DATE: _____

You have requested, or otherwise provided notice, that you may need a leave of absence under the Family and Medical Leave Act for the following reason:

☐ The birth of a child or acceptance of a child for adoption or foster care
☐ Your own serious health condition, including pregnancy
☐ To care for a family member with a serious health condition
(provide name and relationship)_____
☐ A qualifying exigency for a family member in the United States Armed Forces who is called to Active Duty
☐ To care for a family member or next of kin with a serious injury or illness incurred in the line of duty while on active duty in the United States Armed Forces (Military Caregiver Leave)

You have indicated your leave will begin on or about _____ .

The purpose of this notice is to inform you:

☐ You are eligible for FMLA leave
☐ You are not eligible for FMLA leave at this time because:
  ☐ You have not worked for Fort Bend County for at least 12 months
  ☐ You have not worked at least 1,250 hours in the preceding 12 months, or
  ☐ You have already exhausted your FMLA leave entitlement

If you are eligible for FMLA leave, please note that your FMLA leave may not yet be approved. You must return the appropriate certification form within 15 days from receipt of the form. We must have a properly completed certification form in order to classify your leave as protected leave under the FMLA. Failure to provide certification as requested may result in denial of leave.

If your leave is approved as FMLA leave, the following rights and responsibilities will apply:

1. Eligible employees are entitled to a total of 12 weeks of FMLA leave in a 12 month period, (26 weeks for Military Caregiver
2. Leave). The 12 month period is calculated on a rolling 12 month basis measured backward from the date of any FMLA leave usage.
3. You are entitled to continue medical benefits, subject to the same costs and requirements as other employees not on leave. You must continue to pay your share of the premiums, and payment must be coordinated with the Risk Management Department. Under certain circumstances, if you do not return to employment following FMLA leave, you may be required to reimburse Fort Bend County for the County's share of any costs paid on your behalf during your FMLA leave.
4. You are entitled to reinstatement to the same or equivalent position at the same pay, benefits and terms and conditions of employment if your leave does not extend beyond the FMLA entitlement and you adhere to the listed requirements.
5. You are required to contact your supervisor on the first workday of each week or other prearranged schedule to inform them of your status and intent to return to work.
6. You are required to use any accrued paid leave, including sick, vacation, compensatory and deferred time while you are on leave. If all paid leave is exhausted, the remaining leave will be without pay.
7. While on unpaid leave, you will not accrue any benefits such as vacation or sick leave, nor will you receive longevity payments.
8. You must provide re-certification of the need for leave if an extension to your original request is needed.
9. If the leave is due to your own serious illness or injury, you will be required to furnish certification from your medical provider that you are able to perform the essential functions of your position before returning to work. A job description was provided to you with the certification form.

Questions regarding FMLA can be addressed with Human Resources at 281-341-8624.

Signature of Elected Official or Department Head: _____

NOTIFICATION OF LEAVE DESIGNATION – FAMILY AND MEDICAL LEAVE ACT (FMLA)

DATE: _____

TO: _____ (Employee Requesting Leave)

This notice is to inform you that your request for FMLA leave is:

☐ NOT APPROVED, for the following reason(s):

_____

_____

☐ APPROVED. All leave taken for this reason will be designated as FMLA leave. Please note the following:
Given the information you have provided, we anticipate that the following amount of time will be designated as FMLA.

_____ (hours, days or weeks)

If the above space is blank, it means that we are unable to predict how much leave you will need. You have the right to request a report of hours designated as FMLA every 30 days if desired.

Please note the following rights and responsibilities:

1. Eligible employees are entitled to a total of 12 weeks of FMLA leave in a 12 month period, (26 weeks for Military Caregiver Leave). The 12 month period is calculated on a rolling 12 month basis measured backward from the date of any FMLA leave usage.
2. You are entitled to continue medical benefits, subject to the same costs and requirements as other employees not on leave. You must continue to pay your share of the premiums, and payment must be coordinated with the Risk Management Department. Under certain circumstances, if you do not return to employment following FMLA leave, you may be required to reimburse Fort Bend County for the County's share of any costs paid on your behalf during your FMLA leave.
3. You are entitled to reinstatement to the same or equivalent position at the same pay, benefits and terms and conditions of employment if your leave does not extend beyond the FMLA entitlement and you adhere to the listed requirements.
4. You are required to contact your supervisor on the first workday of each week or other prearranged schedule to inform them of your status and intent to return to work.
5. You are required to use any accrued paid leave, including sick, vacation, compensatory and deferred time while you are on leave. If all paid leave is exhausted, the remaining leave will be without pay.
6. While on unpaid leave, you will not accrue any benefits such as vacation or sick leave, nor will you receive longevity payments.
7. You must provide re-certification of the need for leave if an extension to your original request is needed.
8. If the leave is due to your own serious illness or injury, you will be required to furnish certification from your medical provider that you are able to perform the essential functions of your position before returning to work. A job description was provided to you with the certification form.

Questions regarding FMLA can be addressed with Human Resources at 281-341-8624.

Signature of Elected Official or Department Head: _____

☐ For employees on leave due to an illness or injury sustained while working (Workers Compensation Leave): This notice is to inform you that leave taken due to your workers comp qualifying injury or illness will also be designated as FMLA leave. This designation will in no way affect your workers compensation benefits, and you will not be required to use accrued paid leave while you are receiving workers compensation.

FORT BEND COUNTY
SHARED SICK LEAVE POOL DONATION FORM
Form 712-D

TO: Shared Sick Leave Pool Administrator
c/o Human Resources Department

FROM: _____ DEPARTMENT NAME: _____

DATE: _____

Please accept this memo as authorization to deduct hours from my accrued sick leave balance, to be credited to the Fort Bend County Shared Sick Leave Pool (Pool). I am donating _____ hours (minimum = 8 hours, maximum = 40 hours or 80 if terminating or retiring)

The purpose for my donation is:

☐ To self-enroll in the Pool

☐ Pool enrichment donation (I am already a Pool member)

☐ I am terminating employment or retiring from Fort Bend County, and wish to donate a portion of my unused accrued sick leave to the Pool (up to 80 hours may be donated).

OR

Enrollment of Others

☐ I am donating hours (8 minimum) to contribute to the enrollment of another qualifying employee who has worked for the County at least 12 months and has a sick leave accrual balance of 40 hours or more. **A combined total of 40 hours or more must be donated on this employee's behalf.**

_____

(Name and Department of employee to be enrolled)

I have read and understand Section 712, Shared Sick Leave Pool, of the Employee Information Manual. I agree to abide by all the rights and responsibilities detailed in the policy.

Signature of Employee: _____ Date: _____

Printed Name: _____ Department: _____

For questions regarding the Shared Sick Leave Pool, please contact Kathy Novosad in Human Resources at 281-341-8624.

Send this form by interoffice mail to Human Resources, or fax to 281-341-8615, or e-mail to Kathleen.Novosad@fortbendcountytx.gov

FORT BEND COUNTY
SHARED SICK LEAVE POOL WITHDRAWAL FORM

TO: Shared Sick Leave Pool Administrator
c/o Human Resources Department

FROM: _____DEPARTMENT NAME: _____

DATE: _____

SUBJECT: Withdrawal from Shared Sick Leave Pool

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 estimate that the amount of sick leave needed will be _____ hours.

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 Section 712, Shared Sick Leave Pool, of the Employee Information Manual.

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

Requestor's Signature: _____Date: _____

Department Head Signature: _____Date:_____

For Pool Administrator Use Only

Date of committee review:_____		Self-enrolled or EBO	
		Member Since	
Court approval date:_____		Current Position	
		Length of Service	
Payroll notified: _____		Date Began FMLA	
		FMLA Time Remaining	
Department notified: _____		Sick Leave Used	
		Vacation Used	
Employee notified: _____		Comp/Deferred/Other Used	
		Previous Pool Withdrawal	