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 Generalist- Leaves Administration

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

Date: September 26, 2023

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(s) as follows:

An employee of Homeland Security & Emergency Management Position # 5801-0010, 480 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 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: tanya.clayton@fortbendcountytx.gov.

Employee Name: [redacted] Emp. ID: [redacted]

Department/Office: Homeland Secuity & Emergency Management

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: ~~212.29~~ 480

Employee Signature: [redacted] Date: 09/07/2023

Dept. Head Signature: [signature] Date: 9/18/2023

[redacted]