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)