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