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 ____________________________