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| UA-color-left-med | Telecommuting Approval(Periodic/Intermittent or Temporary/Emergency) |  **PMGS 17-02A****PMGS 17-03A**Revised 4-1-21 |
| **I. Employee:** |
|  |
| Name: |       | Employee ID#: |       |  |
|  |  |  |
| Employee Working Title: |       | Employee Line Item Title: |        |
|  |
| This position is eligible for telecommuting: [ ]  Yes [ ]  No |
| Supervisor Name:  |       | Department: |       | Work Location:  |       |
|  |
| **II. Type of Telecommuting** **A.** [ ]  Periodic/Intermittent [ ]  Temporary/Emergency  **B**. Please explain how the employee’s request for telecommuting meets the criteria of the specific telecommuting category checked above. For example, if periodic, what is the need to temporarily work  from a location other than the official work location?      **C.** Provide a detailed explanation of the need for this arrangement.       |
| **III. Proposed Telecommuting Schedule** |
|  |
|  | Start Date  | End Date |  |  |
|  |       |       |  |
|  |
|  | Daily Work Hours/ Schedule  |  |  |
|  |       | **PLEASE NOTE: If an employee does not work their standard hours each day, leave must be taken for hours not worked.**  |
|  |
| **IV. Specific Job Duties/Tasks (You must list all duties/tasks that will be completed by employee.)**. |
|  |
|        |
|  |
| **V. Approval**  |
|   |  |  |  |
| Unit/Department HeadSignature: |  |  Date: |       |
|  **THIS FORM MUST BE SUBMITTED TO HUMAN RESOURCES** |