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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.)**. | | | | | | | | | | | | | | | | | | | | | |
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| **V. Approval** | | | | | | | | | | | | | | | | | | | | | |
|  | | | |  | | | | | | | | |  | | |  | | | | | |
| Unit/Department Head  Signature: | | | |  | | | | | | | | | Date: | | |  | | | | | |
| **THIS FORM MUST BE SUBMITTED TO HUMAN RESOURCES** | | | | | | | | | | | | | | | | | | | | | |