Rev. 06/25
06/15 Issue Obsolete

DCFS WORK SCHEDULE REQUEST FORM

Employee Name:		Personnel Number:		Office/ Region:	
Job Title:			Requested Start Date:		*

***Start Date must be a prospective date at the beginning of a pay period if changing from one work schedule option to a completely different option.**

Check option you are requesting:

☐ **Option 1**: Five 8-hour work days _____ AM to _____ PM with _____-minute (30, 45, or 60) meal period.

☐ **Option 2**: Four 10-hour work days _____ AM to _____ PM with day off on ☐M ☐T ☐W ☐Th ☐F each week with _____-minute (30, 45, or 60) meal period.

☐ **Option 3:** Four 9-hour work days _____ AM to _____ PM and one 4-hour work day _____ AM to _____ AM/PM on ☐M ☐T ☐W ☐Th ☐F with _____-minute (30, 45, or 60) meal period.

☐ **Option 4**: **Available to FLSA Exempt Employees ONLY -** Four 9-hour work days _____ AM to _____ PM. and one 8-hour work day _____ AM to _____ PM for one week of pay period **AND** Four 9-hour work days _____ AM to _____ PM with day off for one week of pay period with _____-minute (30, 45 or 60) meal period

Day off and 8-hour work day occurs on: ☐ M ☐T ☐W ☐Th ☐F

Day off occurs during ☐ Week 1 ☐ Week 2 and 8-hour work day occurs on opposite week.

☐ **Option 5**: **Available to Shift Schedule Employees ONLY** - 24 hours/7 days with varied shift hours in order to provide 24-hour coverage/services.

In requesting this alternate work schedule and signing below I acknowledge and agree that:

- Once a plan is approved, it shall remain in effect for a minimum of three months unless:
  a. returning to a regular five day work week; or
  b. altering or canceling this schedule is determined necessary by supervisor, unit manager or appointing authority to ensure adequate office coverage and/or adequate service delivery; or
  c. unusual situations and/or emergency circumstances warrant change and approved by supervisor, unit manager and/or appointing authority;
- I retain responsibility for all duties, assignments, activities, training requirements, attendance at meetings and service delivery for all assigned cases/clients/customers; and
- I will abide by DCFS Policy 4-20, Work Hours for DCFS Personnel, and understand that failure to do so will result in forfeiture of the alternate work schedule option.
- Substandard performance or work quality on my part may result in this privilege being revoked.

Employee Signature:		**Date:**	

REQUIRED APPROVALS:

☐ **Yes** ☐ **No**	**Supervisor Signature:**		**Date:**	
☐ **Yes** ☐ **No**	**Appointing Authority or Designee Signature:**		**Date:**	

Form Disposition:
☐ Copy to Employee ☐ Original to Employee's Supervisor ☐ Copy to State Office Human Resources Section******

****Submit copy to S.O. HR Section for new employee or for existing employee making change to his/her Work Schedule option. Requests to change hours of work only do not need to be submitted to S.O. HR Section.**

For State Office Human Resources Section Use Only:

Date Entered in LaGov: Entered by: