

**UCONN HEALTH
TELECOMMUTING REQUEST AND DECISION FORM**

PART 1: To be completed by the requesting employee

Name: _____

Department : _____

Current Work Location(s): _____

Job Title: _____ Union: _____

Name and title of Supervisor: _____

Name and title of Manager: _____

Are you currently in an initial or promotional working test period? Yes___ No___

Describe your current daily commute:

Length of commute (one-way):___ miles; ___minutes

Number of ___ commuting trips per week.

Proposed Telecommuting Location:

Address _____ Contact Telephone Number _____

Will another telecommuter work from that location?

Yes___ No___

If yes, list their name(s)/employer(s):

Will other family members be at the telecommuting location while you are telecommuting?

Yes___ No___

If yes, list name(s) and age(s) below.

My current work hours are from _____ to _____, with a ___minute meal break

My proposed telecommuting schedule is:

- Duration: from _____(mm/dd/yy) to _____(mm/dd/yy) (Maximum of 1 year).
- My proposed telecommuting work hours are from _____ to _____, with a ___minute meal break
- I would like to telecommute _____ day(s) per pay week, _____ weeks per month on the following days: (add additional weeks if schedule would fluctuate)
Fri.____ Sat.____ Sun.____ Mon.____ Tues.____ Wed.____ Thurs.____

Describe which of your job duties you will perform at the telecommuting location. Include in your description what materials, records or other work product you need to perform each duty and whether any of those materials are confidential or protected.

Describe how you will communicate with your supervisor, co-workers, and clients while you are telecommuting.

Describe how telecommuting will increase your efficiency and productivity.

- **I have reviewed the UConn Health Guidelines on Telecommuting. I understand my rights and obligations, and I will abide by all applicable policies and procedures.**
- **I understand that I may be required, upon request, to provide proof of family care arrangements and /or of adequate homeowners or rental insurance.**
- **I understand that a Telecommuting Arrangement must be fully approved in writing before I begin telecommuting.**
- **My telecommuting may be modified or end without cause, subject to the restrictions in the Guidelines, at any time.**

Requesting Employee's Signature

Date

Employee: Give this complete Appendix A packet to your supervisor/manager after you have completed Part 1.

PART 2: TELECOMMUTING REQUEST REVIEW BY SUPERVISOR, MANAGER, HUMAN RESOURCES AND AGENCY HEAD

This telecommuting arrangement is approved for the following time period:

From _____ (mm/dd/yy) to _____ (mm/dd/yy)
(Duration may not exceed 1 year).

Telecommuting Location as described above (check): Home Office ___ Alternate Site ___

- The employee is approved to telecommute _____ day(s) per week, _____ weeks per month on the following days:

Fri. _____ Sat. _____ Sun. _____ Mon. _____ Tues. _____ Wed. _____ Thurs. _____

- The telecommuter's approved work hours while telecommuting are from _____ to _____.
- The telecommuter's approved meal period while telecommuting is from _____ to _____.

The following equipment will be used by the employee in the home/alternate site: (please specify whether equipment is agency owned or employee-owned) **Note: IT Property Equipment Loan Form-IC-5 must also be filled out.**

Item _____	Owner _____
Item _____	Owner _____
Item _____	Owner _____
Item _____	Owner _____
Item _____	Owner _____

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The supervisor/manager will monitor the telecommuter's efficiency and productivity as follows: (Any changes to the employee's duties while telecommuting should also be noted here)

- Additional conditions agreed to by the telecommuting employee and management, if any:

Acknowledgements:

- ***This telecommuting arrangement is governed by and complies with the UConn Health Telecommuting Guidelines and all policies and procedures referenced therein, as well as all other applicable state and agency policies and procedures. The undersigned have read, understand and acknowledge abiding by these policies.***
- ***The signatures below indicate approval of this telecommuting request.***

Supervisor _____ Date _____

Manager _____ Date _____

Human Resources
Representative _____ Date _____

Agency Head
(or designee) _____ Date _____

Final Employee Acknowledgment. I have reviewed this approved telecommuting request and agree to abide by it and any changes that have been made to my proposal.

Employee _____ Date _____

Original to be filed in Employee's Personnel File with any related documents.