



County of Santa Clara

CEMA Alternate Work Schedule Request/Decision Form

NOTE: Window period for application during the months of January and July.

Part I – To be completed by Employee

Employee Name: _____ Job Title: _____ Employee ID: _____

Department: _____ Supervisor's Name: _____

Official work Location/Unit: _____

Employee Type: Non-exempt (Requires Labor Relations' written approval) Exempt

I request that I be permitted to work the alternate work schedule outlined below:

Alternate Work Schedule

Day	Week One	Week Two	Total Hours per Pay Period
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			
Total Number of Hours			

If Alternate Work Schedule request is approved, how will service delivery be provided to external customers, internal customers, coworkers, supervisor/manager and others? Please address. Please attach additional pages as needed.

Employee Plan

Employee Signature

I have received, read, and agree to the Alternate Work Schedule policy. I believe that my work can be completed within the above schedule with no loss of customer service nor disruption to others in my department or to the County. Changes/Amendments to the Alternate Work Schedule must be made in writing. I understand that my manager may require me to return to the regular work schedule in accordance with the policy. I also agree to waive any overtime, not required by FLSA, as a result of my participation in the alternate work schedule. This agreement is subject to reevaluation should either party request a review. **I understand I am required to maintain the County-required log for commute savings due to my participation in the Alternative Work Schedules (compressed work week) program.**

Print Employee Name: _____

Employee Signature: _____ Date: _____

This agreement will be in effect as follows: (No more than a 6 month period without renewal)

Beginning Date: _____ Ending Date: _____

Part II - To be completed by Supervisor

I have reviewed the employee's request and I have determined the following:

- Recommended approval
- Recommended approval with modification
- Recommended denial/termination (Check one)

If recommended modification or denial/termination of this request, please explain why:

Print Supervisor Name: _____

Supervisor Signature : _____ Date: _____

Part III – To be completed by Office of Labor Relations (if non-exempt)

- Approved
- Denied (Check one)

Print Office of Labor Relations Name: _____

Office of Labor Relations Signature: _____ Date: _____

If denied, these are the reasons:

Part IV- To be completed by Department Head or Designee

I have reviewed the employee's request and I have determined the following:

- Alternate Work Schedule approved
- Alternate Work Schedule approved with modification
- Alternate Work Schedule denied/terminated (Check one)

If modified or denied/terminated this request, please explain why:

Print Department Head or Designee Name: _____

Department Head or Designee Signature : _____ Date: _____

This decision is final and is not appealable or grievable. An employee may request to meet with the Department Head or Designee to discuss the reason for denial of the Telework schedule request. This meeting shall occur within a reasonable period of time following the denial of the request. In the event the meeting does not occur, the employee can contact Labor Relations for further assistance.

Part V – To be completed by Employee

- I request to meet with the Department Head or Designee to discuss the reason for denial of the Alternate Work Schedule request.

Employee Signature: _____ Date: _____

Department Head or Designee Signature: _____ Meeting Date: _____

Please send the original form with required signatures to ESA personnel file with copies to Department personnel file, Supervisor, Timekeeper, and Employee.

