








**Telework Agreement**

Employee Name:     
Program:   
Position Number:   
Class Title:   
People First Number:   
Supervisor Name:   

Alternative Work Site Information	
Alternative Work Site Address:	<input type="text" value="700 N Adams St"/>
City, State, Zip:	<input type="text" value="Tallahassee FL 32303"/>
Alt. Work Site Phone:	<input type="text" value="(850) 488-4661"/>

Official Work Site/Service Center/Building Name:

Effective Date of Agreement:  

**Telework Participation Classification: (Choose One)**

OPTIONAL     REQUIRED\* (Work at an alternative work site must be documented on the position description)

**Telework Schedule at Alternative Work site: (subject to change upon approval)**

<input type="radio"/>	Less than 16 hours a week
<input checked="" type="radio"/>	16 – 20 hours a week
<input type="radio"/>	21 – 39 hours a week
<input type="radio"/>	40 or more hours a week

I certify I will use approved safeguards to protect Department equipment, information and supplies in accordance with all Department policies, procedures and the [Alternate Worksite Safety Checklist](#).

I understand that, in accordance with the Department’s Telework Policy (Policy), if the Department office or facility, or any portion thereof, which is designated as my official work headquarters, is closed due to a non-emergency or non-disaster condition, as that term is defined in the Policy, or if my home has been designated as my official work headquarters and is not impacted by the closure, I am required to continue to perform my assigned work duties at the approved alternative worksite, and will not receive special compensatory leave credits for work performed during the period the office or facility, or portion thereof, is closed.

Employee Signature: <input type="text" value="Ken Hawkins"/>	Date: <input type="text" value="11/15/2021"/> 
--	---

Supervisor Signature:

Shirley Combass



Date:

11/15/2021



**Note:** Press "Enter" or "Tab" after providing your signature to validate, then make your selection below.

(check one)

Approved

Denied (Complete DENIAL section)

Requires Additional Info

**DENIAL**

Select the reason(s) for denial (check all that apply):

Supervisor	PGM Approver	
<input type="checkbox"/>	<input type="checkbox"/>	A reduction of the individual's or work unit's productivity.
<input type="checkbox"/>	<input type="checkbox"/>	A reduced level of service provided to Department customers.
<input type="checkbox"/>	<input type="checkbox"/>	An increase in the cost of Department operations.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	No program business need.

**Comments:**

Empty text area for comments.

Shirley Combass



CANCEL

SUBMIT