Baystate Health

Request for Flexible Work Arrangement

Section I: Read the Flexible Work Arrangement Policy HR 307 before you complete this request form. Be sure your information is complete. Allow two pay periods for processing. Incomplete information may cause delay in processing this request and could result in payroll errors.

Employee Name: _____ EN: _____ Date of Request: _____

Department Name: _____ CC Number: _____ Status: ❑ Exempt ❑ Non-exempt

Job Title: _____ Manager's Name: _____ Ext: _____

Home address: _____
Street Number Street Name

City: _____ State: _____ Zip: _____

Option A ❑	**Flexible Start and End Time** This allows the employee to work the same number of hours with a non-traditional start and end time. The new schedule is determined in advance and entered into Kronos as the set work schedule.
Option B ❑	**Compressed Work Week** This allows the employee to perform the job at the current FTE, but in fewer days. Indicate the maximum number of hours scheduled in any one day of your new work arrangement. ❑ 8 hours ❑ 9 hours ❑ 10 hours ❑ 12 hours
Option C ❑	**Partial Telecommuting** This allows the employee to work from home or an alternate location for a portion of the regular work week.
Option D ❑	**Voluntary Reduction in Hours** This allows a full-time employee to work six months at full-time status and six months at .8 FTE status, averaging .9 FTE over a 12-month period to maintain health and dental benefits at the full-time rate. This option will result in a corresponding reduction in pay for the employee. Check the box for the six-month cycle you are requesting. ❑ April to September (.8 FTE) followed by October to March (full time) ❑ October to March (.8 FTE followed by April to September (full time)

Current Work Schedule

Scheduled Hours	Example	SUN	MON	TUE	WED	THURS	FRI	SAT	TOTALS
Week 1 Schedule	8 a.m. to 4:30 p.m.								
Week 1 Hours	8								
Location	BMC								
Week 2 Schedule	8 a.m. to 4:30 p.m.								
Week 2 Hours	8								
Location	BMC								

Proposed Work Schedule

Scheduled Hours	Example	SUN	MON	TUE	WED	THURS	FRI	SAT	TOTALS
Week 1 Schedule	7 a.m. to 3:30 p.m.								
Week 1 Hours	8								
Location	BMC								
Week 2 Schedule	7 a.m. to 3:30 p.m.								
Week 2 Hours	8								
Location	BMC								

If approved, what impact would this Flexible Work Arrangement have on your patients, co-workers, supervisors and others in the workplace? Consider both positive and negative impacts.

_____

_____

_____

What solutions do you propose to address any impact?

_____

_____

_____

What is your primary reason for this request? (Optional)

❑ Care for a family member ❑ Ease commute ❑ Education
❑ Pursue professional/personal interests ❑ Volunteer service ❑ Other

If this arrangement cannot be met in the department, would you be willing to consider and alternative option?

❑ Yes ❑ No

If approved, what is your desired start date?

_____

I have read and understand the guidelines in the Flexible Work Arrangements HR Policy 307. I understand that the final decision to approve this request is at the discretion of the Director or VP of my department.

_____

Employee's Signature Date

To be completed by the employee's Manager and Director or VP

After review of the policy and guidelines and in consideration of the business needs of the department, this request is:

❑ Approved ❑ Not approved

If approved, the Flexible Work Arrangement will be effective on (date)_____ (The effective date must be at the beginning of a pay period. Allow 2 pay periods for processing when setting the effective date.)

_____

Manager's name Manager's Signature Date

_____

Director's or VP's name ***Director's or VP's Signature*** ***Date***

Instructions to Manager:

- **If approved, complete Section II.**
- **If not approved, send a copy of Section I to the HR Service Center at your location and maintain a copy for your files.**

Section II: **Complete this 'Agreement for Flexible Work Arrangement' after Section I is approved by the director or VP. This is an agreement between the manager and the employee, and is required for processing any flexible work arrangement. Please keep a copy in your files and provide a completed copy to the employee.**

_____

Employee Name

Your request for a Flexible Work Arrangement for Option _____ has been approved:

Your new schedule will begin on (pay period beginning date) _____.

This agreement outlines the details of your new work arrangement. Read it completely and sign the statement of agreement.

The details of your Flexible Work Arrangements are as follows:

Scheduled Hours	SUN	MON	TUE	WED	THURS	FRI	SAT	TOTALS	Location
Week 1 Schedule									
Week 1 Hours									
Location									
Week 2 Schedule									
Week 2 Hours									
Location									

**Include an additional 30 minutes in your schedule for a lunch break if you are working more than 6 hours per day.*

1. This arrangement will be in effect for _____ months, at the end of which time you and I will review the arrangement and determine whether it will continue.

2. If at any time this arrangement no longer meets the business needs, the arrangement may be discontinued. If you wish to terminate this agreement, you must provide notification in writing 30 days in advance.

3. All obligations, responsibilities, terms and conditions of employment with Baystate Health remain unchanged, except those obligations and responsibilities specifically addressed in this agreement.

4. If organizational needs require, there may be times when it is necessary for you to forgo your flexible work arrangement to support business needs. You are expected to make every attempt to adjust your schedule accordingly.

5. This work arrangement will have no effect on your salary, unless you selected Option D; Voluntary Reduction in Hours. Depending on choice of flexible work agreement, there may be some impact on PTO. (See policy appendix for additional info). _____ (employee initial)

6. If a partial telecommuting schedule is approved, it is your responsibility to arrange your alternate work location accordingly to accomplish productive work and minimize distractions.

7. If you are in a leadership role (defined as supervisor or above), you must consider the impact on patient care and staff relations and plan ways to maintain effective communication and visibility. You will meet this criteria by the following efforts:

   a.

   b.

   c.

8. Additional provisions for this arrangement include: (List)

   a.

   b.

   c.

9. You and I will meet every _____ (months) to discuss how the flexible work arrangement is working and make adjustments as needed.

STATEMENT OF AGREEMENT

I, _____ understand that Baystate Health is not obligated to provide me
(Name)
with a flexible work arrangement. The decision to approve a request for a flexible work arrangement is at the discretion of Baystate Health management. Flexible work arrangements are subject to ongoing review and may be subject to termination at any time based on my employee status, job performance, or change in business needs. I understand that any change in this arrangement is non-disputable in the Baystate Health Dispute Resolution Policy (BH-HR-806.)

I hereby affirm by my signature that I have read the Flexible Work Arrangement Policy 307 and this agreement. I understand and agree to all of its provisions and details.

_____

Employee's Signature Date

_____

Manager's Signature Date

Instructions to Manager:
- **Send a copy of Section I and II to the HR Service Center at your location.**
- **Maintain a copy for your files.**
- **Provide a copy to the employee.**

Agreement Cancellation (for Human Resources use only)

Effective date: _____ **HR initials** _____

Reason for cancellation: _____

_____