

Employee Eligibility Requirements and Agreement Remote Work Arrangement

General Guidelines

After reviewing the *Remote Work Arrangement Policy BH-HR-315*, the manager and employee must review and complete, in its entirety, the Employee Eligibility Requirements and Agreement. **If requirements are met and approved, both manager and employee will sign the Statement of Agreement** on page four.

A Remote Work Arrangement is not an entitlement and can be changed at any time by Baystate Health. The following employee requirements for managing their remote work arrangement may vary by business unit.

*The **employee** must **initial to the left of each item** indicating that they have read and understood each area within the agreement.*

_____ **Massachusetts or Connecticut Work Location.** I acknowledge that my alternative work location is located in the state of Massachusetts or Connecticut. At this time, Baystate Health can only support remote work arrangements for employees who live in Massachusetts or Connecticut. The appropriate state W4 withholding certificate must be completed for tax purposes.

_____ **Baystate Health Equipment.** I have read the *Technology Guidelines*. I understand and agree to follow the guidelines on acquiring network connection, servicing the equipment, how to troubleshoot, and the process for returning Baystate Health equipment.

Confidentiality. I understand that:

_____ Baystate Health equipment and confidential materials will be kept secure from unauthorized persons at all times and is to be used for business purposes only.

_____ If I step away from my work space, I understand that I need to log off the computer.

_____ I understand and will comply with all Baystate Health policies including those specific policies outlined in the policy section within this document.

Work Space. I have a clearly defined private work space that is kept clean and orderly. I will dedicate a room or part of a room to job-related activities. This space is shielded from household noise, and has a locked door for security and privacy. The space is large enough to accommodate: (check all that apply)

___ Desk

___ Comfortable chair

___ Phone

___ Computer

___ Printer

___ Fax machine

___ Locking filing cabinet

_____ Exits, doorways, aisles, and corners are free of obstructions to permit visibility and movement. File cabinets and storage closets are arranged so drawers and doors do not enter into walk ways.

_____ Phone lines, electrical cords, and surge protectors are secured under a desk or alongside a baseboard. All electrical equipment is free of recognized hazards that would cause physical harm (i.e. frayed wires, bare conductors, exposed or loose wires of fixture on the ceiling or walls)

_____ The alternate work location's electrical system permits the grounding of electrical equipment. A grounded power outlet and a surge protection device should be used.

_____ I have read the documents: *Computer Workstation Ergonomics: Posture, Process and Environment* and *Computer Workstation Ergonomics: Components* and I understand the proper ergonomics and workstation requirements necessary to do my job safely.

_____ I understand the Baystate Health has the right to inspect my alternate work office for safety standards.

_____ I understand that my alternate work office physical address is not to be used for meetings with employees, customers, providers, patients.

Emergency Preparedness

_____ If I incur a work-related injury at my alternate work location, I am required to report it immediately to my manager, regardless if I feel it is necessary or not.

_____ Emergency phone numbers (hospital, fire department, police department) are available at the alternate work location.

_____ I have a first aid kit that is easily accessible and is replenished as needed.

_____ I have portable fire extinguishers that are easily accessible and serviced as needed.

_____ I am able to receive phone calls and voicemails from managers, co-workers, and customers.

Dependent Care (if applicable)

_____ Primary care for dependents during the telecommuting hours, have been arranged. I understand that remote working is not a substitute for dependent care.

_____ Policies

In addition to operating in accordance with all Baystate Health policies, I have read, understand and will comply with the following specific policies:

- *Confidentiality: BH HR 802*
- *Privacy: BC 7.010*
- *Remote Access: BC 6.940*
- *Workstation Security: BC 6.830*
- *Password & User ID: BC 6.840*
- *Information Security: BC 6.820*
- *Information Security Incident Reporting & Response: BC 6.860*
- *Desktop Technology: BC 6.310*
- *Travel Reimbursement policy*
- *Evening Night and Shift Differentials: HR 403*
- *On Call and Unscheduled Call In: HR 405*

Expectations and Performance Standards.

_____ I understand that management may consider job performance as a condition for approval and continuation of the remote work arrangement.

_____ I understand that my manager will set up a schedule to meet with me regularly to discuss performance and this remote work arrangement every _____ months.

_____ I understand that my manager will clearly define what work I am responsible for and what performance standards are required. The deliverables will be results oriented and measurable. (Manager: A separate sheet should be used and attached.)

Reimbursable Expenses

_____ I will follow the Baystate Health and my department process for submitting for reimbursement.

_____ I understand that the following expenses are reimbursable by Baystate Health:

Time Keeping/Daily Management

_____ I understand that my work schedule is as follows:

Schedule & Hours	Example*	SUN	MON	TUE	WED	THUR	FRI	SAT	TOTAL
Week 1: Schedule	8 am - 4:30 pm								
Week 1: Hours	8								
Week 2: Schedule	8 am - 4:30 pm								
Week 2: Hours	8								

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

_____ I understand what my daily work schedule is and how many hours I am to work each day and week. Any variations from the established schedule must be approved in advance by my manager.

_____ I understand that I need to e-mail the *Remote Worker Timecard* to my manager by the end of each workweek.

_____ I understand that I am not to work more than _____ hours per week without prior approval.

_____ To request time off, I need to: _____

_____ If I am unable to work on a specified day, I need to: _____

_____ I understand that I am required to take meal and rest breaks each day. During this time, I am not on the clock and therefore should not be working.

_____ I understand that I may be required to travel to an onsite location for team meetings, etc.



Statement of Agreement

Remote Work Arrangement

To be Completed by the Manager and Employee

Employee First Name: _____ Employee Last Name: _____ EN: _____

Employee Home Address:

Street number Street Name City State Zip Code

Employee's Signature

Date

This employee has been approved for a remote work arrangement. This arrangement will be effective _____ (mo/day/year).

The effective date must be at the beginning of a pay period. Please allow about two pay periods for processing when setting the effective date.

Manager's First/Last Name

Manager's Signature

Date

Instructions to Manager:

- Send a copy of this agreement to the HR Service Center at your location.
- Maintain a copy for your files.
- Provide a copy to the employee.



Termination of Agreement

Remote Work Arrangement

Termination of Agreement

This remote work arrangement was terminated on _____ (date) for this reason:

I will return Baystate Health equipment within 30 days of signing this Termination of Agreement.

Employee First/Last Name

EN

Employee's Signature

Date

Manager's First/Last Name

Manager's Signature

Date

Reason for Termination of Agreement: _____

Instructions to Manager:

- Send a copy of this agreement to the HR Service Center at your location.
- Maintain a copy for your files.
- Provide a copy to the employee.