COUNTY OF RIVERSIDE
TELECOMMUTING APPLICATION

EMPLOYEE SECTION

Date: _____

Employee Name: _____

Employee ID Number: _____

Department: _____

Job Classification: _____

Immediate Supervisor/Manager Name: _____

PROPOSED TELECOMMUTING SCHEDULE							
Day	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Indicate a ✓ on telecommuting day(s)							
Indicate scheduled hours, including lunch break while telecommuting							

Reason for requesting to telecommute:

Description of work to be conducted while telecommuting:

Is there any work you would not be able to conduct while telecommuting?

What equipment do you currently have at home that will be voluntarily used for your telecommuting assignment?

What type of equipment would you benefit from and boost productivity?

The following characteristics relate respectively to your job duties you have listed above. Please rate each characteristic as either high (H), medium (M), low (L) by placing the appropriate letter in the blank before each statement.

_____ Amount of face-to-face contact required with the public/clients/employees.
_____ Degree of telephone communications required.
_____ Amount of in-office reference material required.
_____ Ability to perform job duties independently.
_____ Ability to control and schedule workflow.
_____ Clear understanding of job expectations.

I understand that telecommuting is a voluntary arrangement between the Supervisor/Manager, the Department, and the employee, and is not an entitlement or employee benefit. I understand that telecommuting may be terminated for any reason, at any time, by any party. I certify that I have read and understand the Board Policy K-3, Telecommuting Program and the Telecommuting Program Guide and will comply with all requirements if approved by the Department to telecommute.

Employee Signature: _____ Date: _____

Upon completion forward original to your immediate Supervisor/Manager.

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SUPERVISOR/MANAGER

Supervisor/Manager Name: _____

I have verified the following with regard to the above-named employee:

- ☐ The employee is maintaining satisfactory performance standards.
- ☐ The employee's work performance demonstrates the ability to work independently.
- ☐ Current job requirements do not necessitate a full-time presence on the premises or "in-person" contact with the public or other Departmental staff and/or if they do, arrangements have been made for the adjustment.

Budget Impact:

Recommendation for Approval/Denial:

- ☐ Recommend approval of application as requested by employee
- ☐ Recommend approval of application with modifications (see comments below)
- ☐ Recommend denial of application (see comments below)

Supervisor/Manager's Comments:

Supervisor/Manager Signature: _____ **Date**:_____

- ✓ Return original to the employee and keep one copy for your Supervisor/Manager records.
- ✓ If recommended for approval, instruct the employee to complete the required Telecommuting Training and the Telecommuting Work Program Agreement pursuant to the agreed upon terms in the above application.