



Change in Availability Request Form

Changes to availability must be submitted 30 days prior to implementation date

Staff Name: _____ Site #: _____ Date of Request: _____

Date of desired change in availability: _____

Place an "X" in the boxes provided indicating when you are **not able** to work due to other obligations

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
6a→630a							
630a→7a							
7a→730a							
730a→8a							
8a→830a							
830a→9a							
9a→930a							
930a→10a							
10a→1030a							
1030a→11a							
11a→1130a							
1130a→12p							
12p→1230p							
1230p→1p							
1p→130p							
130p→2p							
2p→230p							
230p→3p							
3p→330p							
330p→4p							
4p→430p							
430p→5p							
5p→530p							
350p→6p							
630p→7p							
7p→730p							
730p→8p							
8p→830p							
830p→9p							
9p→930p							
930p→10p							
10p Asleep ON							
10p Awake ON							

Additional Preferences: (If possible, I prefer mornings, etc...) _____

How many hours do you want to work each week? Minimum: _____ Maximum: _____

If necessary to meet your desired hours, are you willing to work at another site?

Yes No

Marking "No", indicates that I understand and accept this could result in a possible reduction in my scheduled weekly hours.

I understand my request may require me to transfer to another site to fit my desired hours*:

Staff Signature: _____

*Implementation of this request will be subject to site needs and management approval.



Change in Availability Request Form

Changes to availability must be submitted 30 days prior to implementation date

You may be asked to discuss this request in detail with your supervisor(s).

Administration Only

Date Received: _____

Supervisor Signature: _____ Date: _____

Approved: Yes: Effective on _____

No: If no, why: _____

Reviewed by STM/HSA: _____ Date: _____

- ✓ Original to HR
- ✓ Copy to STM/HSA
- ✓ Copy to SC/HS
- ✓ Copy to Counselor

Revised 8/2011