

# Compressed Work Week Agreement

As of 2013

Employee Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

Department/Division/Work Unit: \_\_\_\_\_

Employee Work Headquarters: \_\_\_\_\_

Telephone Numbers: Office: \_\_\_\_\_ Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Home Address: \_\_\_\_\_

Date to Begin Trial Compressed Work Week Arrangement: \_\_\_\_\_

Date to End Trial Compressed Work Week Arrangement: \_\_\_\_\_

Indicate below your current work schedule showing the actual hours of work per day in a ten day cycle, (e.g., Monday, 8:30 a.m. - 12:30 p.m., 1:30 p.m. - 4:30 p.m.). Confirm your proposed compressed work week schedule by specifying the actual work hours requested per day in a work cycle.

*Note: You must work a total of \_\_\_\_\_ hours in a work cycle.*

Current Work Week Schedule						Proposed Compressed Work Week Schedule							
Days	Week One			Week Two			Days	Week One			Week Two		
	Hours			Hours				Hours			Hours		
	AM	Lunch	PM	AM	Lunch	PM		AM	Lunch	PM	AM	Lunch	PM
Monday							Monday						
Tuesday							Tuesday						
Wednesday							Wednesday						
Thursday							Thursday						
Friday							Friday						
<b>Total Hours Worked</b>							<b>Total Hours Worked</b>						

Please confirm the requested earned time off in a ten day cycle by checking the week, day and time of day (i.e., AM / PM).

- Week:  1                       2
- Day:  Monday       AM       PM
- Tuesday       AM       PM
- Wednesday     AM       PM
- Thursday       AM       PM
- Friday          AM       PM

**Employer / Employee Reviews**

Meetings between the Employee and the Director/Manager/Supervisor will be scheduled every \_\_\_\_\_ (indicate time frame) to review the compressed work week arrangements and to discuss any needed adjustments. This agreement may be terminated by the employer or the employee on \_\_\_\_\_ calendar days notice, except in cases of emergency or any agreed upon circumstances where no notice will be required.

**Conditions Required by the Employer**

Indicate any specific requirements the employer places on the employee as part of the compressed work week arrangement.

**Employee Agreement**

I have read and understand the compressed work week guidelines and Q & A's. I agree to the conditions of my requested arrangement as contained in this agreement. I also understand that this flexible work arrangement can be modified or terminated at the department's discretion.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Employer Signatures**

Director / Manager / Supervisor: \_\_\_\_\_

Deputy Minister: \_\_\_\_\_ Date: \_\_\_\_\_

**Compressed Work Week Review**

This Compressed Work Week arrangement is:

- extended to \_\_\_\_\_ (date).
- modified as noted below effective \_\_\_\_\_ (date).
- canceled as of \_\_\_\_\_ (date).

Comments:

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer Signatures:

Director/Manager/Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_

Deputy Minister: \_\_\_\_\_ Date: \_\_\_\_\_

**cc: Director of Strategic Human Resource Management Division  
Personal file of (insert employee's name)**