



ALTERNATE/COMPRESSED SCHEDULED REQUEST

Employee Name: _____

Date: _____

Department: _____

Job Title: _____

Proposed Scheduled

Date	Start Hour	Meal Period	End Hour

Total number of work hours per work week: _____

Alternate/Compressed Schedule Agreement

I have read and acknowledge all provisions in Policy 5.05 Flextime & Compressed Work Week Schedule and agree to work the approved alternate work schedule from _____, 20__ to _____, 20__.

Employee Signature

Date

Please Note:

The Fair Labor Standards Act (FLSA) requires that overtime compensation be paid at one and one-half times the regular hourly rate for each hour worked over 40 hours during the non-exempt employee's designated workweek. Averaging work hours over different work weeks is not permitted.

DIRECTOR ACTION

Request Recommended: From _____, 20__ to _____, 20__

Request Denied- Comments: _____

Department Director

Date