






FLORIDA

Telework Agreement



Employee Name:   *

Program:  *

Position Number: *

Class Title: *

People First Number: *

Supervisor Name:   *

Alternative Work Site Information	
Alternative Work Site Address:	<input type="text"/> *
City, State, Zip:	<input type="text"/> *
Alt. Work Site Phone:	<input type="text"/> *

Official Work Site/Service Center/Building Name:

Effective Date of Agreement:  *


Telework Participation Classification: (Choose One)

OPTIONAL REQUIRED* (Work at an alternative work site must be documented on the position description)

Telework Schedule at Alternative Work site: (subject to change upon approval)

<input type="radio"/>	Less than 16 hours a week
<input type="radio"/>	16 – 20 hours a week
<input type="radio"/>	21 – 39 hours a week
<input type="radio"/>	40 or more hours a week

I certify I will use approved safeguards to protect Department equipment, information and supplies in accordance with all Department policies, procedures and the [Alternate Worksite Safety Checklist](#).

Employee Signature: <input type="text"/>   *	Date: <input type="text" value="5/18/2021"/> 
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