EMPLOYEE REQUEST FOR CHANGE IN WORK SHIFT OR DAYS OFF

(This Application to be filed with Immediate Supervisor)

NAME OF APPLICANT

______________________________________________________________

(Last)                                          (First) (Middle)

PRESENT DEPARTMENT ________________________________

PRESENT TITLE ________________________________

PRESENT GRADE _____ PRESENT SHIFT ________________ SHIFT DESIRED ________________

PRESENT DAYS OFF ___________________ DESIRED DAYS OFF ________________________________

COMMENTS OR INFORMATION YOU WOULD LIKE TO MAKE CONCERNING THIS REQUEST:

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Date of Application)                                (Signature of Employee)

(THIS FORM MUST BE RENEWED ON OR AFTER JANUARY OF EACH YEAR)

. . . . . . . . . . . . . . Do Not Write Below This Line . . . . . . . . . . . . . .

FOR DEPARTMENT USE ONLY:

ADMINISTRATIVE GROUP OF APPLICANT ________________________________

CAMPUS SENIORITY DATE OF APPLICANT ________________________________