**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 <u>EACH</u> YEAR)

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

FOR DEPARTMENT USE ONLY:

ADMINISTRATIVE GROUP OF APPLICANT _____

CAMPUS SENIORITY DATE OF APPLICANT _____