COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH

EMPLOYEE REQUEST TO TELECOMMUTE

NAME: _____ DATE: _____

TELECOMMUTING LOCATION:
- ☐ Home _____
- ☐ Other DMH office _____
- ☐ Other _____

		Start	*Finish*	***Effective Date(s)***
SCHEDULE:	☐ Monday	_____am	_____pm	From: _____
	☐ Tuesday	_____am	_____pm	To: _____
	☐ Wednesday	_____am	_____pm	☐ Ongoing
	☐ Thursday	_____am	_____pm	
	☐ Friday	_____am	_____pm	

DMH EQUIPMENT USED: _____

_____

_____

ARRANGEMENTS FOR HANDLING BUSINESS CALLS TO AND BY THE TELECOMMUTER (e.g., MCI card):_____

_____

_____

TELECOMMUTER AND SUPERVISOR AGREE TO THE FOLLOWING CONDITIONS:

Telecommuter will:

- ☐ Call supervisor at the beginning of each workday
- ☐ Be available to supervisor at all times during telecommuting shift
- ☐ Complete timely all work assigned by supervisor
- ☐ Maintain a comprehensive written work log of assignments
- ☐ Meet weekly with supervisor to review work progress
- ☐ Submit completed work to supervisory timely
- ☐ Attend all meetings, as required by supervisor
- ☐ Regularly check voicemail
- ☐ Return all calls promptly

OTHER CONDITIONS:

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

SPECIFIC METHODS OF MEASURING PRODUCTIVITY: _____

_____

_____

_____

OTHER: _____

_____

_____

_____

WE HAVE REVIEWED, UNDERSTAND AND AGREE TO THE ABOVE CONDITIONS FOR TELECOMMUTING

_____ _____
Employee's signature Date

_____ _____
Supervisor's signature Date

_____ _____
Manager's signature Date

c: DMH Telecommuting Coordinator, Administrative Support Bureau (original)
Personnel File
Employee
Supervisor
Manager