MONTHLY TELECOMMUTING REPORT

TO: Department Telecommuting Coordinator
Administrative Support Bureau

FROM: _____ _____
Manager's Name Signature

_____ _____ _____
Clinic/Office Pay Location Date

Telecommuting details for this clinic/office for the month of _____ are:

Name	Employee Number	Date	Time	Hours	*Telecommuting Assignment *Provide brief description*

***Does NOT include field work**

c: Deputy Director