Change of Shift/Status Acknowledgement

Name: Effective Date:

Department: Manager:

Current Schedule		New Schedule	
Monday	_____	Monday	_____
Tuesday	_____	Tuesday	_____
Wednesday	_____	Wednesday	_____
Thursday	_____	Thursday	_____
Friday	_____	Friday	_____
Saturday	_____	Saturday	_____
Sunday	_____	Sunday	_____
Total hours per week	_____	Total hours per week	_____

Change in Status: ☐ **Yes** ☐ **No**

PT Employee not eligible for benefits: 29 hours per week or less
PT Employees eligible for Medical/Dental/Vision Coverage: 30 to 39 hours per week
PT Employees eligible for partial PTO/partial Holiday pay: 32 to 39 hours per week
Full Time Employees: 40 hours per week

I hereby acknowledge that my change of shift change will be approved. By signing below, I acknowledge that my shift will be changed, effective the date above, and agree to be held accountable for my attendance as noted in the Employee Manual.

Signatures

_____ _____

Employee Date

_____ _____

Manager / Supervisor Date

_____ _____

Department Director Date

_____ _____

Human Resources Representative Date

For Internal Use Only:

☐ Signed COS Letter ☐ Signed COS Acknowledgement ☐ Updated GGOB ☐ Updated Benefits Census