utmb Health
Preventive Medicine
& Community Health

Flexible Work Schedule Agreement

Employee Name: _____ **Date of Agreement:** _____

Supervisor: _____ **Administrator:** _____

I wish to flex my: ☐ **Hours** ☐ **Work week** ☐ **Lunch**

Description: _____

_____

Back-up coverage for my duties will be provided by: _____

Additional Comments: *(Please be specific if you have special considerations.)*

_____

_____

_____ _____

Employee Signature **Date**

_____ _____

Supervisor Signature **Date**

_____ _____

Administrator Signature **Date**

Flex Time Guidelines

1. Once approved, any variation of the agreement will require the approval of your supervisor.
2. Supervisors must review this agreement quarterly and may make adjustments based on the needs of the program or department.
3. The supervisor may void this agreement at any time if the terms stated or not met or the needs of the program or department change.