STATE OF IDAHO TELECOMMUTING APPLICATION

EMPLOYEE INFORMATION:

Name	Title
Job classification	Work phone
Agency	Office location
Division	Department
Supervisor	Agency Appointing Authority/Designee

TELECOMMUTE INFORMATION:

This application is a request for: (see policy for definitions)

☐ Regular and/or reoccurring schedule	☐ Periodic and/or intermittent
☐ As a component for a Reasonable Accomodation[1]	☐ An out of state telecommuting request[2]
Will you be providing dependent care while performing official work duties[3]? ☐ Yes ☐ No	

How often are you requesting permission telecommute? (choose only one and designate specific day of the week) Note: This option is only available for work performed within the State of Idaho.

Once a week (day)_____	Two days a week _____	Three days a week _____
Four days a week _____	Five days a week _____	Occasional for special projects ☐

Work hours:_____

Designated work location:_____

Other work locations (if applicable):_____

Reasoning why the employee is requesting this agreement:

1. This must be submitted to and approved by the Employee's agency prior to telecommuting.
2. Out of State telecommuting agreements require employees to work entire pay periods in one location and require DHR and DFM pre-approval.
3. Dependent care does not prohibit an employee from telecommuting. Telecommuting is not to be viewed as a substitute for dependent care and must be disclosed. Telecommuters with dependent care situations are encouraged to have alternative solutions for providing care during the agreed upon work hours.

Please read each of the following job characteristics and then rate each according to your current job requirements. If there is a **High** requirement, **Low** requirement, or **No** requirement for this aspect in your personnel skillset or your job, please mark a **X** in the appropriate column.

High ratings for items 1-7 below and low ratings for items 8-12 tend to indicate that the job and / or the person is compatible with the telecommuting program. However, your supervisor / management team will use your responses as only one part of their decision to approve this application.

Job Requirements	High	Low	None
Ability to control and schedule work			
Clear and understandable work assignment objectives			
Ability to work autonomously			
Requirement to concentrate on work			
Amount of computer work			
Clear understanding of computer security requirements			
Amount of face-to-face contact			
Amount of telephone communications			
Amount of in-office reference material needed			
Amount of generally sensitive material / data			
Amount of HIPAA material work requirement *(Health Insurance Portability and Accountability Act which requires employers to physically separate and safeguard employees' "protected health information" received from a group health plan.)*			
Amount of tax information work/Personally Identifiable Information			

TELECOMMUTE WORK PLAN PROPOSAL:

Briefly describe the work that you wish to complete while telecommuting
(e.g., 20% email, 30% data management, 25% phone consultations):

Briefly describe the telecommuting location and workspace including necessary equipment. Note: an agency may not be responsible for providing telecommute equipment.

If you are providing dependent care while performing official duties, describe how you will manage disruptions and distractions during an agreed upon work time:

Briefly describe how telecommuting will meet the goals of your work unit and needs of the State:

Employee Name (printed)_____ Employee Signature_____ Date _____

Supervisor's Comments:

Supervisor Name (printed)_____Supervisor Signature_____ Date_____

Agency Determination. Provide justification if the telecommuting application is denied.

☐ Denied ☐ Approved

_____

Agency Appointing Authority/Designee Name (printed)_____

Agency Appointing Authority/Designee Signature_____ Date_____

If applicable: DHR Representative:_____ Date:_____

DFM Representative:_____ Date:_____

SCO Representative:_____ Date:_____

cc: Agency Human Resource office