

SECTION 1: STAFF MEMBER'S DETAILS

Employee Number	2 2 8 9 9	Classification	
Title:	MRS	Family Name:	MCPHERSON (nee HALLETT)
		Given Name(s):	EMMA-KATE
Position Title:	Medical Scientist	Clinical Program/Group:	
Ward / Area:	Haematology	Location:	Pathology
Email address:	E.HALLETT@ALFRED.ORG.AU	Contact Number:	BH: 0433 336 462 AH: 0433 336 462

N.B.: Have you completed 12 months of continuous service
 Yes – Proceed with application
 No – As you have not completed 12 months continuous service you are ineligible to apply for Flexible Working Arrangements.

SECTION 2: FLEXIBLE WORKING ARRANGEMENT

Please indicate the arrangement you are applying for:

Flexible start and finish times	Compressed work week	Job Share (Proposal of other employee to be attached also)	Change of Location
Working from Home <small>Please attach Working from home agreement documentation (Working from Home Guideline Prompt)</small>	Reduction in Contracted Hours	Reduction in Classification	
Date you request flexible working arrangement to start:	Jan 2020		
Date you request flexible working arrangement to end:	Unknown		
What is the duration of the flexible working arrangement?			
3 months	6 months	9 months	12 months
			Other: (less than 12 months)
Proposed return to substantive fraction / working arrangement date:			Unknown

SECTION 3: SCHEDULE PROPOSED

Provide details of the schedule proposed where this is relevant to the request:

	Start / Finish times and Shift Length	Location	Special Arrangements
Monday			
Tuesday			
Wednesday	0700 - 1530		Every 2nd week
Thursday	0700 - 1530		
Friday	0700 - 1530		
Saturday			
Sunday			
Total Fortnight/ Weekly Hours	40 hrs FN /		

SECTION 4: ADDITIONAL INFORMATION (To be completed by the requesting employee)

Why are you requesting a flexible working arrangement, please state the reason for the request?

I am the primary carer for my 2 year old child.

Are you a parent or have responsibility for the care of a child who is school age or younger?	<input checked="" type="radio"/> Yes	<input type="radio"/> No
Are you a carer within the meaning of the <i>Carer Recognition Act 2010</i> (Cth)?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Do you have a disability?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Are you 55 or older?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Do you wish to access Alfred Health's Family Violence leave?	<input type="radio"/> Yes	<input checked="" type="radio"/> No
Are you providing care and support to a family member who requires care or support because they are experiencing violence from the member's family?	<input type="radio"/> Yes	<input checked="" type="radio"/> No

What is the likely impact upon your duties and your work role if the flexible working arrangement is approved?

No impact.

What do you consider to be the likely impact upon the work unit/department and other team members if the flexible working arrangement is approved?

No impact.

What other arrangements have you considered? Would you be prepared to move to another role or department if necessary to accommodate the request for the flexible working arrangement?

N/A.

Do you have any other information that you wish to have taken into consideration?

I am requesting a change of start times due to child care obligations (fortnightly hours to remain the same).
I am requesting mon - Fri shifts only as my husband frequently travels for work on weekends & I have no alternative child care arrangements.

SECTION 5: ACKNOWLEDGEMENT & SIGNATURE OF EMPLOYEE

1. I declare that the information I have provided is accurate and true.
2. Notwithstanding any representation to the contrary, I acknowledge that Alfred Health may refuse to approve my request for a flexible working arrangement on reasonable grounds.
3. I acknowledge that this request is conditional upon and subject to approval by relevant approvers of Alfred Health.
4. If applicable, I acknowledge that the request for a flexible work fraction is for an agreed period and that Alfred Health is under no obligation to continue this arrangement beyond the agreed period. Upon the expiry of this agreed period I acknowledge that I will return to my existing work schedule in my substantive position unless otherwise agreed. This does not preclude a subsequent application or request for extension.
5. I acknowledge that if Alfred Health has agreed to approve my flexible working arrangement by adopting the proposed schedule contained in section 3 of this application for an agreed period, that after the expiration of the agreed period Alfred Health is under no obligation to continue this arrangement. Upon the expiry of this agreed period I acknowledge that I will return to my existing work schedule in my substantive position unless otherwise agreed.

Signature:	<i>Emma McPherson</i>	Print Name:	Emma-Kate McPherson	Date:	16/10/19
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Note: If the request is approved the new arrangements will otherwise be in accordance with conditions of employment as provided with your existing contract of employment. Workforce guidelines, procedures and policies may be found in in PROMPT as varied from time to time.

SECTION 6: AUTHORISATION BY CLINICAL PROGRAM/DEPARTMENT (other than unpaid leave)

Approved in employee's substantive position as per the proposed schedule contained in section 3 of this application	Yes	No*
Approved in position other than employee's substantive position	Yes	No*
Is this position on a trial basis?	Yes	No

Position:

* If the request cannot be accommodated in the staff member's substantive position or other position, the Clinical Service Director and Manager / Supervisor must complete Section 7 'Refusal of working arrangements on reasonable grounds'. Additionally, for agreed alternative arrangements, the head of unit and supervisor must complete Section 8 'Authorisation' by Alfred Health for an alternative arrangement'.

Supervisor			Head of Unit		
Signature:			Signature:		
Name:			Name:		
Date:		Ext:	Date:		Ext:

SECTION 7: REFUSAL OF FLEXIBLE WORKING ARRANGEMENTS ON REASONABLE GROUNDS

(to be completed for all refusal of requests for flexible working arrangements)

Manager to consult with Alfred Health Employee Relations prior to final decision being made.

Reasons for refusal:

Signature:	
Name:	
Date:	Ext:

SECTION 8: AUTHORISATION BY ALFRED HEALTH FOR AN ALTERNATIVE ARRANGEMENT

Position/details:

Manager / Supervisor		Clinical Service Director			
Signature:		Signature:			
Name:		Name:			
Date:		Ext:		Date:	
Staff member					
Signature:					

Manager / Supervisor to complete:
I have provided the applicant with a copy of the application outlying Alfred Health's response within 21 days of the application being received.

Managers Name		Signature		Date provided:	
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Manager / Supervisor to complete
Does this agreement require a change to Employees contract of employment (Decrease in Hours or Classification?) Yes / No
If Yes please complete below

Variation E Hub number:		Date processed:		Input by:	
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FOR PAYROLL OPERATIONS USE ONLY

Pay period:		Date processed:		Processed by:	
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