

## DOE Flex Application

Employee's Name:	
Position Title & Series:	Alternative Worksite Telephone No
Organization:	
Alternative Worksite Address:	Supervisor's Telephone No.
Supervisor's Name:	
Type of DOE-Flex Arrangement: [ ] Routine [ ] Situational [ ] Medical* Routine- ___ day(s) per- week / pay period (please circle) *Medical documentation is required and should be submitted with Medical telework application.	
1. Describe the specific work to be performed at the alternative designated work site.	
2. Briefly describe how you meet the criteria for participation and the benefit to the EMCBC.	
3. Briefly describe the suitability of the alternative designated worksite for <b>DOE-Flex</b> , to include designating the specific office space, equipment, etc.	
4. List any resources that you will need to perform your official duties.	
Employee Signature	Date

## ACTION ON APPLICATION

### ROUTINE:

Approval - Supervisor's Signature & Date	Disapproval - Supervisor's Signature & Date
Reason for Disapproval (if applicable)	Date

### MEDICAL/SITUATIONAL:

Recommend Approval – Supervisor's Signature & Date	Recommend Disapproval – Supervisor's Signature & Date
Reason for Disapproval (If applicable)	Date
EMCBC DOE-Flex Program Coordinator's Signature	Date
Approval - EMCBC, Director's/Deputy Director's Signature	Date
Disapproval – EMCBC Director's/Deputy Director's Signature	Date
EMCBC Director's/Deputy Director's Reason for Disapproval	Date

Pay Period Work Week	Day	Tour of Duty Hours (ex. 8:00 – 4:30)		Duty Station	
				Official	Alternative
<b>Week 1</b>	Monday				
	Tuesday				
	Wednesday				
	Thursday				
	Friday				
<b>Week 2</b>	Monday				
	Tuesday				
	Wednesday				
	Thursday				
	Friday				