



Personal Care Agency | Home Health Agency

Shift Change Request Form

This form must be completed by the employee(s) who agreed to work the shift.
The form must be submitted **at least 72 hours** in advance to the Program Manager.

Name of Person WHO CANNOT work the shift:	Name of Person WHO AGREED work the shift:
Shift Date: (Example: Monday, January1, 2007)	Shift Time: (Example: 24-hour or 2:30 pm to 11:00 pm)

You will be notified of your request within 24 hours.

- By completing this form, all parties are indicating that they agree to the listed shift changes and will uphold the agreement.
- Each party will receive a copy of this form, if approved by a Program Manager, for their records.
- Any change made without approval by a Program Manager, or any shift left without coverage, will be a violation of company work schedule policy and will be dealt with in accordance with the employee handbook.
- **Shift changes may not result in overtime.**
- If overtime is unavoidable, it must receive prior authorization from the Program Manager and Program Director.

Employee Signature

Date

Employee Signature

Date

Office Use

Date Request Received: _____

Approved Denied Reason: _____

Program Manager Signature

Date