State of Delaware
Department of Human Resources

TELECOMMUTING POLICY AGREEMENT FORM	
Policy #: To be assigned	**Authority:**
Effective Date: June 22, 2020	**Supersedes:** March 16, 2020

SECTION A: Telecommuting Information

Alternate Work Location:

Street Address: _____

City: _____ State: _____ Zip Code: _____

Description of Alternate Work Location:

_____

Telecommuting Schedule:

Regular telecommuting work days: _____

Regular telecommuting work hours: _____

Systems to be accessed from alternate work location (*For example: PHRST, FSF, DEL, etc*):

_____

Equipment and software required for remote access (*For example: Laptop, Egress, etc)*:

_____

Performance Objectives: _____

_____

_____

_____

SECTION B: Employee Certification

I have read and understand the attached Telecommuting Policy and agree to the duties, obligations, responsibilities and conditions for telecommuters described therein.

I agree that, among other things, I am responsible for establishing specific telecommuting work hours, furnishing and maintaining my alternate work location in a safe manner, employing appropriate telecommuting security measures and protecting the State of Delaware's assets, information and systems. I may be financially responsible for expenses incurred while telecommuting based on my agency's requirements.

I understand that telecommuting may be discontinued at any time at the request of the Agency Supervisor. I understand that I may request the telecommuting arrangement be discontinued, and the Agency supervisor must review and provide a response within 5 business days. I also understand that employees may be required to telecommute or work from alternate work locations based on non-discriminatory, operational needs of the Agency.

This agreement is effective on (Date): _____ through (Date): _____

_____

Employee Printed Name

_____ _____

Employee Signature Date

_____ _____

Manager/Supervisor Signature Date

_____ _____

Division Director Signature Date