WASHOE COUNTY TELECOMMUTING AGREEMENT

This agreement between _____ of_____ Department is effective from _____ to_____.

Telecommuting location:

_____

Address City, State Zip

_____

Telephone Email address

Days and hours for the telecommuter: _____

Reason for telecommuting:

_____

_____

Assignments for the telecommuter: ☐ Regular Job Duties or ☐ Special Assignment

If Special Assignment, please state assignment and method(s) of measurement:

_____

_____

For Technology Services Use Only: Equipment Meets TS Standards: ☐ YES or ☐ NO

I understand and agree to adhere to the telecommuting guidelines established in the Washoe County Telecommuting Policy. I understand Washoe County will not be responsible for costs incurred as a result of telecommuting. Management may terminate this agreement at any time with up to two days' notice. I understand Washoe County's Workers' Compensation Program will cover me only during the authorized scheduled hours stated above. I agree to maintain the prescribed workstation. In the event of an accident occurring during the authorized time period I MUST immediately report the injury to my supervisor.

_____ _____

Employee SAP# Date

_____ _____

Department Head Date

_____ _____

Technology Services Date

cc: Human Resources