Employees may submit this application to request to participate in the [SUNY-wide Telecommuting Program](https://hr.buffalostate.edu/telecommuting-program). Requests are subject to the approval of their supervisor, department head, and Cabinet member. Determinations as to which job functions are eligible for telecommuting is subject to management discretion and based on operational need. An employee’s participation in the telecommuting arrangement may be modified, suspended, or cancelled at any time by management, in consultation with HR, with 30 calendar days advance written notice to the employee where feasible and consistent with operational needs, based on operational needs, performance concerns, or any other non-discriminatory reason.

All requests must be based on the expectation that Buffalo State College, and all its units/offices, are open for in-person business, providing forward-facing services with adequate staffing to meet the needs of our community. We understand that due to the nature of their work, not all employees have the flexibility to make use of the telecommuting program. An employee should initiate a conversation with their supervisor, if they wish to and believe they can perform their essential duties and responsibilities with the telecommuting program. Please review the [SUNY-wide Telecommuting Program Policy](https://hr.buffalostate.edu/sites/hr.buffalostate.edu/files/uploads/Documents/SUNY-wide_Telecommuting_Program_Policy.pdf) before submitting your request.

**Note:**

* A telecommuting work arrangement shall not commence until it has received written final approval.
* The maximum allowable days per pay period that may be approved for telecommuting is 5 (five) workdays and in no event will an employee telecommute for their full obligation.
* An employee must submit to their immediate supervisor/manager progress reports describing work completed while telecommuting on a periodic basis. If an employee fails to do so, their telecommuting agreement will be cancelled.

1. **Employee Information (to be completed by the applicant):**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please check one: | | new application  application for renewal | | | | | | |
| Last Name: |  | | | | | First Name: |  | |
| Budget Title: |  | | | | | | | |
| Department: |  | | | | | Supervisor: |  | |
| Employee Work E-mail: | | |  | | | Employee Work Desk Phone: | |  |
| Bargaining Unit or Union: | | | |  | | Employee Work Cell Phone: | |  |
| Current Work Schedule (hours/days):  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday  Hours: | | | | | | | | |
| Are you currently serving a probation\* period? | | | | | Yes  No | | | |
| *If unsure, please contact HR.* | | | | |  | | | |

1. **Equipment**

|  |  |  |  |
| --- | --- | --- | --- |
| Do you have a state-issued laptop? | Yes  No | Inventory Tag/Device ID: |  |
| Do you have a personal computer? | Yes  No |  | |

1. **Personal Privacy Protection Law Notification**

The information you are providing will be used to determine your eligibility to participate in the Telecommuting Program. This information will be retained by Human Resources. Failure to provide the requested information may result in a delay in processing or denial of your application.

It is the responsibility and the intent of the State of New York to fully comply with the provisions of article 6-A of the Public Officer’s Law, the Personal Privacy Protection Law. The Personal Privacy Law protects you from the random collection of personal information by state agencies. The law enables you to access and/or correct information on file which pertains to you. It also regulates disclosure of personal information to persons authorized by law to have access for official use.

**Telecommuting Work Plan**Rationale for the Telecommuting Agreement (please describe the reason for the request/assignment):  
  
       
  
**Telecommuting Location:**

|  |  |
| --- | --- |
| Address of Work Location: |  |
| Telephone: |  |
| E-mail: |  |

**Work Schedule:**I will be available to my manager and other key customers during the following times as part of this agreement:

|  |  |
| --- | --- |
| Start Date of Telecommuting Schedule: |  |
| End Date of Telecommuting Schedule: |  |
|  | |
| \*Regular Telecommuting Schedule (include days and hours you will be working at the telecommuting work location. All other workdays are presumed to be on campus.):  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday  Hours and/or schedule details:  **\*Note, the maximum allowable days per pay period that may be approved for telecommuting is 5 (five) workdays and in no event will an employee telecommute for their full obligation.** | |

**Performance Goals and Work Plan:**

|  |  |  |  |
| --- | --- | --- | --- |
| Projects/Job Functions to be performed while telecommuting: | Observable measures that demonstrate successful progress on each Project/Job Function: | Contacts/Others involved in completion of project: | Deadline Date: |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |

1. **Attestation**

I have received, read, and will comply with the [SUNY Telecommuting Program](https://hr.buffalostate.edu/sites/hr.buffalostate.edu/files/uploads/Documents/SUNY-wide_Telecommuting_Program_Policy.pdf) and my campus policies and procedures.  
By entering your name, you are signing this document and agree to abide by all rules and guidelines.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Employee Name |  | Date |

Submit this application to your immediate supervisor/manager for review.

**This section should be completed by immediate supervisor/manager within 7 days of receipt.**

Date submitted to immediate supervisor/manager:

I have reviewed the application and the employee:

Meets criteria

Does not meet criteria (if this option is selected, you must complete 1. and 2. below)

1. Choose all that apply:

performance concerns

duties require physical presence at official work site

technology/equipment limitations

operational hardship

tasks cannot be quantified and/or evaluated

other

1. Provide additional information to support your decision:

By entering your name, you are signing this document.

|  |  |  |  |
| --- | --- | --- | --- |
| Supervisor/Manager Name: |  | Date: |  |
| Supervisor/Manager Title: |  |  |  |
| Supervisor/Manager E-mail: |  |  |  |

**This section should be completed by Department Head/Chair within 7 days of receipt.**

Date submitted to Department Head/Chair:

I have reviewed the application and the application is:

Meets criteria

Does not meet criteria (if this option is selected, you must complete 1. and 2. below)

1. Choose all that apply:

performance concerns

duties require physical presence at official work site

technology/equipment limitations

operational hardship

tasks cannot be quantified and/or evaluated

other

1. Provide additional information to support your decision:

By entering your name, you are signing this document.

|  |  |  |  |
| --- | --- | --- | --- |
| Department Head/Chair Name: |  | Date: |  |
| Department Head/Chair Title: |  |  |  |
| Department Head/Chair E-mail: |  |  |  |

**This section should be completed by next level supervisor below VP (if needed) within 7 days of receipt.**

Date submitted to next level supervisor:

I have reviewed the application and the application is:

Meets criteria

Does not meet criteria (if this option is selected, you must complete 1. and 2. below)

1. Choose all that apply:

performance concerns

duties require physical presence at official work site

technology/equipment limitations

operational hardship

tasks cannot be quantified and/or evaluated

other

1. Provide additional information to support your decision:

By entering your name, you are signing this document.

|  |  |  |  |
| --- | --- | --- | --- |
| Next level supervisor Name: |  | Date: |  |
| Next level supervisor Title: |  |  |  |
| Next level supervisor E-mail: |  |  |  |

**This section should be completed by Cabinet member within 7 days of receipt.**

Date submitted to Cabinet member:

|  |  |  |  |
| --- | --- | --- | --- |
| Cabinet member Name: |  | Date: |  |
| Cabinet member Title: |  |  |  |

This agreement is:

Approved

Rejected. If this option is selected, please justify why:

Distribution: Employee, Human Resources, Supervisor/Manager, Department Head/Chair, Dean/Director/AVP, VP/Provost

rev 6/29/2023