

OPTIONAL FLEXIBLE WORK ARRANGEMENT ASSESSMENT

Supervisor:

Employee:

Date:

Check the type of flexible work arrangement being addressed:

- Flextime/Flex Schedule
- Telework/Flex place
- Compressed Work Week
- Reduced Hours/Part-Time
- Job Sharing
- Occasional Flex
- Shift Flexibility
- Other: (i.e., Gradual return to work, Meeting free flexibility, Quiet time, No early/late meetings)

Check the column that best reflects your opinion.

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE	NO OPINION
Communication with coworkers and supervisor has been effective.					
Customer service has been effective.					
Other employees have not been adversely affected.					
Work assignments have been completed successfully.					
Safety and security of employee and company equipment has been maintained.					
Any concerns and problems have been resolved in a timely manner.					
The arrangement has been beneficial for our workplace.					

Comments:

Would you recommend any changes take place with this flexible work arrangement?

Will this flexible work arrangement continue?

YES

NO

If not, please explain the adjustments that will take place to the employee's schedule and the reasons for the change.

The next evaluation will occur on:

Employee

Date

Supervisor

Date