

# ROANE STATE COMMUNITY COLLEGE

## Request for Alternate Work Schedule

NAME \_\_\_\_\_  
Last First Middle

Department \_\_\_\_\_

Work Week \_\_\_\_\_  
From: To:

Day	Hours Worked	Annual Leave	Holiday	Comp Time	Total Hours
Sunday					
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Total Hours					

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by Immediate Supervisor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approved by Department Head

\_\_\_\_\_  
Date