



Temporary Reduction of Workforce Form

Name: _____ Clock #: _____

Current Department: _____

Current Position _____

- This form is to acknowledge that I have requested to be temporarily laid off during a temporary reduction of the workforce. I will, if granted, be temporarily laid off effective as soon as possible for a maximum of (check one):
 6 Weeks 8 Weeks 12 Weeks 18 Weeks 24 Weeks
- I understand that acceptance will be based on the Company's overall need and the Company maintains the right to deny my request.
- I understand that the Company retains the right to recall me at any time with one (1) week's notice.
- I understand that I must be cleared by the Employee Services Department before returning to work.
- I understand that I must be physically cleared for work by the clinic before returning to work if I have been out on layoff for 90 days or more.

Signature: _____

Date: _____

Management
Witness: _____

Union
Witness: _____