CALIFORNIA DEPARTMENT OF CORRECTIONS
EXCHANGE OF DAYS OFF-SHIFT ASSIGNMENT (MUTUAL SWAP) FORM

Institution: _____ Date Submitted: _____

Each employee shall be responsible for the coverage of the work assignment he/she accepted. If the employee who agrees to work for another employee fails to show for the swap, and provides proper medical verification, he/she shall be subjected to repaying the actual length of the shift. The State shall first use the appropriate accrued time credits for the repayment, then use "accounts receivable" should time credits be insufficient for the repayment. Once the employee makes reimbursement, the employee may not be subject to adverse personnel action for this incident.

All swaps must be paid back within 90 calendar days. Where the payback cannot be accomplished without overtime being earned by one or both of the affected employees, the requested swaps will be denied.

Once approved, shift changes shall not be subjected to further review except for operational needs. If a shift swap is denied, the supervisor denying the swap shall stated the reason for denial on the swap form request. The employee exchanging hours of work shall not be entitled to any additional compensation, which would not have otherwise been received.

I, _____ _____ _____ _____
(Relieving Staff-Print Name) (Relieving Staff-Signature) (PPAS / Pay #) (Probationary)

agree to work for _____ _____ on _____ / _____ / _____
(Staff being relieved-Print) (PPAS / PAY#) (Month) (Day) (Year)

in Position: _____ _____ from: _____ to: _____
(Relieved Post Description) (Relieved Post #) (Start Time) (End Time)

_____ Approved _____ Denied _____ Date: _____
(Immediate Supervisor's Signature) (Approval Date)

If denied, indicate by number(s) listed below, the reason for denial: _____

I, _____ _____ _____ _____
(Relieving Staff-Print Name) (Relieving Staff-Signature) (PPAS / Pay #) (Probationary)

agree to work for _____ _____ on _____ / _____ / _____
(Staff being relieved-Print) (PPAS / PAY#) (Month) (Day) (Year)

in Position: _____ _____ from: _____ to: _____
(Relieved Post Description) (Relieved Post #) (Start Time) (End Time)

_____ Approved _____ Denied _____ Date: _____
(Immediate Supervisor's Signature) (Approval Date)

If denied, indicate by number(s) listed below, the reason for denial: _____

DENIED FOR THE BELOW INDICATED REASON (S)

1. Position and/or work hours conflict
2. "Open Dates" are not allowed
3. Less than 24 hours advanced notice
4. Medical Restrictions
5. Probationary staff limited to 1 swap per week
6. Involves probationary staff with less than 90 days service
7. Mandatory training day
8. Assignment requires specific training or knowledge
9. Will result in more then 2 back-to-back double shifts
10. Other (specify): _____

It is the employee's responsibility to transmit copies of this form, prior to the shift swap to the SAB and his/her immediate supervisor