

**FACULTY OF MEDICINE AND HEALTH**

**FLEXIBLE WORKING REQUEST TO REDUCE HOURS**

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| **NAME** |  |
| **DEPARTMENT** |  |
| **EMPLOYMENT START DATE** |  |

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| Please detail the hours you are currently working, the hours you are requesting, length of time you would like to reduce your hours for (if less than five years) and the reason for the request. Please make sure you discuss with your line manager prior to submitting your form |

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| --- | --- |
| **Signature** |  |
| **Date** |  |
| **Line manager signature**  |  |
| **Date** |  |
| **Head of School/ Institute Signature** |  |
| **Date** |  |

*Please submit your completed form to your Faculty HR Manager*  FW1