SCHEDULE ADJUSTMENT APPLICATION FORM

Employee Name: _____
Position Title: _____
Department/Location: _____
Supervisor Name: _____
Date of Hire: _____
Total Months Employed: _____

Section 1: Academic Program Information

University/College Name: _____
Degree Program: ☐ Master's in ABA ☐ Psychology ☐ Education ☐ Other: _____
Expected Graduation Date: _____

Internship/Practicum Start Date: _____
Internship/Practicum End Date: _____
Semester Applying For: ☐ Fall ☐ Spring ☐ Summer
Number of Hours Required Per Week: _____

Brief Description of Internship/Practicum Duties:

_____
_____
_____
_____

Section 2: Proposed ABA Schedule Adjustment

Requested Adjustment:
Please describe your proposed schedule changes, including preferred working hours and days:

_____
_____
_____

Requested Adjustment Period:
Start Date: _____ End Date: _____

_____

Section 3: Eligibility Verification

To qualify, staff must meet the following requirements (to be verified by HR/Clinical Admin):

Requirement	Minimum Standard	Verified By	Meets Requirement
Employment Duration	≥ 1 year	_____	☐ Yes ☐ No
Compliance Score	≥ 85%	_____	☐ Yes ☐ No
Performance Standing	Good standing (no active PIP)	_____	☐ Yes ☐ No

Section 4: Required Documentation

Please attach the following:
☐ Proof of active enrollment (e.g., current transcript, enrollment letter)
☐ Documentation of internship/practicum hour requirements
☐ Proposed schedule and university supervisor contact information
☐ Current compliance score summary (provided by HR/QA team)

Section 5: Employee Statement

I am requesting an adjusted ABA session schedule to fulfill internship/practicum requirements for my graduate program. I understand that:

- Approval is **not guaranteed** and depends on eligibility and company operational needs.
- A maximum of **two staff members per semester** may be approved for this adjustment.
- I must maintain a **compliance score of at least 85%** throughout the approval period.
- Approval, if granted, will not exceed **two academic semesters.**
- The company may revoke or modify approval if operational demands or performance concerns arise.

Employee Signature: _____ Date: _____

Section 6: Supervisor Review

Supervisor Comments/Recommendations:

☐ Approved ☐ Denied
Supervisor Signature: _____ Date: _____

Section 7: Clinical & HR Review

Program Director Review:
Comments:
_____
☐ Approved ☐ Denied

Clinical Director Signature:
_____ **Date:**_____

HR/Operations Manager Signature: _____ Date: _____

Section 8: Final Approval

Approved Adjustment Period:
From _____ To _____

Semester Count Toward Two-Semester Maximum: ☐ 1st ☐ 2nd

File Copy: ☐ Employee File ☐ HR ☐ Clinical Administration