

26-Backfill



Employee Movement - Temporary (Higher Duties/Acting at Level)

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An approved 'Validation of Claims Older Than Three Months Form' must be provided in addition to this form if this claim is older than three months from the effective date.

This form is to be used by Queensland Health employees and line managers to document a temporary change to an employee's existing position or temporary appointment to a position either in an 'at level' or higher duties capacity.

Please refer to HR Policy B28 Higher Duties Section 7.3 in relation to the payment of higher duties on public holidays.

Employee Data

Person ID	Personnel acknowledgment number (PAN)	Please Indicate (✓) here if you work in more than one position in QLD Health.
		<input type="checkbox"/>
Family name	First name/s	
Corbett	Danielle	

Visa Notification (if applicable)

If the employee to whom this movement applies holds a Temporary Business (Long Stay) Subclass 457 visa, the Department of Immigration and Citizenship (DIAC) must be notified within 10 working days of the transfer to a new location or position.

Email address:

Note: The sponsorship obligations for visa holders are transferred to the new HR Unit (refer HR Policy B46 for details).

Proposed change type

Higher duties ☐ Acting at level ☒

Indicate below if this form relates to either a new appointment, an extension to an existing appointment or a modification of a previously documented appointment

New ☐ Extension ☐ Modification ☒

Proposed position details

Request to fill a Vacancy Form attached ☐

Position ID	Position title	Classification (e.g. AO4)
3 0 4 6 9 6 3 1	Psychologist	HP4.4
Start date	End date	Percentage of allowance payable applies only to employees under the provisions of the Public Service Act
3/2/14	28/03/14	
Organisational unit number	Organisational unit name	Percentage of allowance
7 0 0 7 1 6 0 5	Psychology MH The Park	%

Facility address

Cnr Ellerton Drive and Wolston Park Road, Wacol, Qld 4076

Job advertisement reference (if applicable)

Current occupant (if applicable)

Farida Steemson

Reason for higher duties / acting at level

Temp relocation for meaningful duties - awaiting VR exit date

Employment Basis

Full-time ☐ Part-time ☒ No. of part-time hours / fortnight: 38

Concurrent / Aggregator: Please Indicate (✓) here if the employee will continue to hold another position in conjunction with the proposed position in ☐

Award/EBA Name

Health Practitioner (Queensland Health) Certified Agreement (No.2) 2011

Start/Movement Details

Reason for vacancy

Exceeding aft temporarily to remove from BAC cost centre & locate meaningful work

Work Contract

Working arrangements	Shift arrangements	Recreation leave accrual	Reason for additional weeks leave
19 day month (ADO accrual) <input type="checkbox"/>	Single shift only <input checked="" type="checkbox"/>	4 weeks / annum <input checked="" type="checkbox"/>	Working public holidays <input type="checkbox"/>
Standard hours (non ADO accrual) <input checked="" type="checkbox"/>	Two shifts <input type="checkbox"/>	5 weeks / annum <input type="checkbox"/>	Continuous shift work <input type="checkbox"/>
Variable working hours <input type="checkbox"/>	Continuous shift work <input type="checkbox"/>	6 weeks / annum <input type="checkbox"/>	Working with radium (radiographers only) <input type="checkbox"/>
9 day fortnight <input type="checkbox"/>	12 hour shift arrangement applies <input type="checkbox"/>		

Special conditions/Allowances (e.g. RANIP Nurses, uniform, laundry allowance etc.). Please refer to the Payroll and Rostering Intranet Site (PARIS) for more information.

Professional Development Leave and Allowance



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Employee Reference

Person ID

Personnel assignment number (PAN)

Work schedule

Please indicate (✓) here if this employee works either:

A cyclic roster (where the roster pattern repeats at regular intervals e.g. fortnightly / monthly)

☐

OR

A non-cyclic roster (a roster pattern that varies from one cycle to the next)

☐

Please complete the table below using 24 hour time format (eg. 07:00 - 15:30) to advise the employee's roster for their initial two week period of employment.

Week one

Day	Start time	End time	Meal break start time	Meal break end time	Total daily hours (ie 7.6)
Monday	9:00	17:06	12:00	12:30	7.6
Tuesday					
Wednesday	9:00	17:06	12:00	12:30	7.6
Thursday					
Friday	9:00	17:06	12:00	12:30	7.6
Saturday					
Sunday					
Total weekly hours					22.8

Week two

Day	Start time	End time	Meal break start time	Meal break end time	Total daily hours (ie 7.6)
Monday	9:00	17:06	12:00	12:30	7.6
Tuesday					
Wednesday					
Thursday					
Friday	9:00	17:06	12:00	12:30	7.6
Saturday					
Sunday					
Total weekly hours					15.2

Where a paid meal break applies, please insert 1/24 for meal break start and end times.

Qualification payments

Please list here any approved qualifications that this employee possesses that will entitle them to additional payment (e.g. relevant AQF qualifications or nursing credentials) under Queensland Health policy.

QLD Health HR Solution User Access Request status

Does the employee have/require Workbrain/SAP access?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Does the current access to Workbrain/SAP require a change?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
Has a QLD Health HR Solution User Access Request Form been completed for the change?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> Not applicable

Supervisor's certification (mandatory completion required)

I certify that I have:

- (where the employee is seeking release or extension of a previously approved movement from another work unit) successfully negotiated the terms of the agreement with the line manager of the employee's substantive position
- informed this employee of any changes to their FBT Concession Eligibility status as a consequence of this variation to their employment
- discussed with this employee the consequences of this change to their position, employment status, terms of employment and/or roster and
- informed the employee where this change applies to a temporary employee moving between temporary assignments, of any impact (i.e. the ending or likelihood of extension of their previous contract) as a consequence of accepting appointment to this proposed position.

Supervisor's signature

Date

Area code

Contact number

06/02/14

Supervisor's full name (please print)

Supervisor's position title

Lorraine Dowell

Team Leader Non Secure Services



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Employee Reference

Person ID

Personnel assignment number (PAN)

Employee certification (mandatory completion required) (refer note below)

I agree to the above changes to my employment hours/position. I hereby claim for the extra remuneration for hours worked in a higher duties capacity (where applicable). I also certify that I have been informed by my line manager/supervisor of the consequences of this change to my:

- FBT Concession Eligibility status that may result from this variation to my employment contract and
- position, employment status, terms of employment and/or roster. I also acknowledge that as this appointment is of a temporary nature, the contract may be ended by my line manager with the appropriate notice in accordance with award provisions.

Employee's signature

Date

Supervisor's signature in lieu*

06/02/14

*In exceptional circumstances where the employee is unable to sign this form (as above) the Supervisor may submit this form for processing where it has otherwise been completed in full and details of the reason that the employee cannot sign the form is listed below. The signature of the employee must be obtained on this form as soon as they become available to sign the form so that it can be retained as a formal contract of employment.

On recreation leave. Unavailable to sign.

14/12/14

Delegate Approval (mandatory completion required)

If the employee's entitlement to recurring allowance changes, please complete and forward the relevant form/s.

HES / SES Higher Duties only:

Will the employee be allocated a government owned motor vehicle for private use or home garaging during this period of relief?

Yes ☐No ☐

Delegate's signature

Sharol Kelly

Date

Area code

Delegate's Contact number

Executive Director

Delegate's full name (please print)

Mental Health & Specialised Services

Delegate's position title

This area is provided for ease of filing

Processing Area Use Only

Processor's signature

Date

Reviewer's signature

Date

Processed fortnight ending