



SHIFT PREFERENCE FORM

This form is provided for your use to indicate your preference for a regular shift assignment. As openings occur, the department will make assignments based upon qualifications and Hospital seniority.

Please supply all information indicated below and **return this form to your Department Head.**

It is the employee's responsibility to inform his/her supervisor of any changes in the shift preference.

Name: _____ Department: _____

Classification: _____ Hire Date: _____

Social Security Number or History Number: _____

Choice of Shift

Indicate 1st, 2nd, 3rd and 4th choice in appropriate space:

____ DAY

____ EVENING

____ NIGHT

____ ROTATING

Signature & Date