Queensland Government

REGISTERED DATE 3/2/14 BY

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

Privacy disclaimer: Personal information collected by Queensland Health is handled in accordance with the Information Privacy Act 2009. The information provided by you will be securely stored and will be made available to appropriate authorised officers of Queensland Health or agents employed by Queensland Health. Personal information recorded on this form will not be disclosed to other parties without your consent unless required by law.

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.

Employee Details

Person ID

Personnel assignment number (PAN)

Please indicate (✓) here if you work in more than one position in QLD Health. ☐

Family name: **KOP**

First name/s: **PETER**

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: QLD.Sponsor.Monitoring@immi.gov.au
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: 3 0 4 6 9 7 6 3

Position title: **CRU- REGISTERED NURSE**

Classification (eg. AO4): **GRADE 5**

Start date: **03-02-2014**

End date: 1/6/14

Percentage of higher duties allowance payable applies only to employees under the provisions of the Public Service Act

Percentage of allowance: %

Organisational unit number: 7 0 0 7 1 5 8 8

Organisational unit name: **CENTRAL RESOURCE UNIT**

Facility address: **THE PARK CENTRE FOR MENTAL HEALTH**

Job advertisement reference (if applicable)

Current occupant (if applicable)

Reason for higher duties / acting at level: **Implementation of new Mental Health Structure**

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

Employment Basis

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

Award/EBA Name: **Queensland Health Nurses and Midwives Award - State 2012 - Section C - Psychiatric Hospitals and Eventide Homes**

Staff Movement Details

Reason for vacancy: **Implementation of new Mental Health Structure**

Work Contract

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

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

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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 (hh:mm)	End time (hh:mm)	Meal break* Start time (hh:mm)	Meal break* End time (hh:mm)	Total daily hours (i.e. 7.6)
Monday	as	per	roster		
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
				Total weekly hours	

Week two

Day	Start time (hh:mm)	End time (hh:mm)	Meal break* Start time (hh:mm)	Meal break* End time (hh:mm)	Total daily hours (i.e. 7.6)
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
Saturday					
Sunday					
				Total weekly hours	

*Where a paid meal break applies, please insert N/A 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?	☐ Yes ☒ No
Does the current access to Workbrain/SAP require a change?	☐ Yes ☒ No
Has a QLD Health HR Solution User Access Request Form been completed for the change?	☐ Yes ☒ Not applicable

Supervisor 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: 22/1/14

Area code: (07)

Contact number

Supervisor's full name (please print): WILLIAM BRENNAN

Supervisor's position title: DIRECTOR OF NURSING

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Employee Reference

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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*

*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.

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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 | Date: 29/1/14 | Area code: (07) | Delegate's Contact number

Delegate's full name (please print): **SHARON KELLY**

Delegate's position title: Sharon Kelly
Executive Director
Mental Health & Specialised Services

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Processing Area Use Only

Processor's signature | Date | Reviewer's signature | Date | Processed fortnight ending