

## REDUCED RESPONSIBILITY LETTER- PMA

Date \_\_\_\_\_

Name \_\_\_\_\_

Dept \_\_\_\_\_

Dear \_\_\_\_\_:

The purpose of this letter is to confirm the details of your request for reduced responsibility under Personnel Policy 6-15. All matters referred to below become effective \_\_\_\_\_ (date).

1. Your employment status will continue to be Regular Full-Time.
2. You will be paid on the basis of \_\_\_\_\_ hours per week and your salary will be adjusted accordingly to \$\_\_\_\_\_.
3. Benefit coverage will also be adjusted in proportion to your salary (pension contribution, life insurance and long term disability).
4. Your annual weeks of vacation entitlement remains unchanged at \_\_\_\_\_, however these weeks will be based upon \_\_\_\_\_ hours of work, for a total of \_\_\_\_\_ hours vacation time. Remuneration for vacation will be based upon your actual rate of earning at the time of the vacation.
5. Recognition of applicable statutory holidays will depend on Personnel Policy 6-5 and the appropriate provision of the Employment Standards Act of Ontario.
6. Sick leave, if required, will apply as usual with any application for long term disability benefit being related to the first day of absence of a scheduled day of work.
7. Within the initial two-year period and with 30 days' notice, return to the original conditions of employment will be automatic at the request of the member of staff. (If the staff member agrees, this right may be waived). Conversely, the University will inform the member of staff 30 days prior to any change in the contract period.

I understand and agree to the conditions outlined above.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Human Resources Consultant (Staff Relations)

\_\_\_\_\_  
Dept. Chairman/Director/Unit Head