Tripartied Pharmacist Part - Time Sixth Day Overtime Waiver Form

I voluntarily agree to waive overtime pay for working on sixth (6th) day in a workweek. I understand that notwithstanding this waiver, I am entitled to overtime pay after eight (8) hours in any one day and after forty (40) hours in any one week.

This agreement may be rescinded upon two (2) weeks notice.

Date Submitted: _____

Pharmacist's Name: _____

Pharmacist signature: _____

Union signature: _____

Company signature: _____

After signing and obtaining the signature of a company representative, please submit this form to your Union Representative for consideration.

Pharmacists - please retain a copy for your records.