MEAL PERIOD WAIVERS

WAIVER FOR EMPLOYEE WORKING A SHIFT OF NOT MORE THAN SIX (6) HOURS

I hereby agree to waive my meal period when I work a shift of six (6) hours or less. This waiver may be revoked at any time.

SIGNATURE of EMPLOYEE:_____ DATE_____

PRINT NAME of EMPLOYEE: _____ DEPARTMENT:_____

HR REPRESENTATIVE:_____ DATE:_____

WAIVER FOR EMPLOYEE WORKING A SHIFT IN EXCESS OF TEN (10) HOURS

[HR to check the appropriate box below before you complete this section]

☐ This will certify that I am an employee working in the Healthcare Industry as defined in California Wage Orders 4 & 5 (provide patient care, work in a clinical/medical department or work as a member of a patient care delivery team), and that when I work a shift in excess of ten (10) hours, I wish to waive one of the two meal periods I would otherwise be entitled to receive under California law. I understand that as a result of this waiver, I will receive only one meal period during each day of work and will be paid for all working time. I also understand that I, or the Hospital, may revoke this "Meal Period Waiver" at any time by providing at least one day's advance notice in writing of the decision to do so. This waiver will remain in effect until I exercise, or the Hospital exercises, the option to revoke it.

☐ This will certify that when I work a shift in excess of ten (10) hours but not more than 12 hours, I wish to waive the second of the two meal periods I would otherwise be entitled to receive under California law. I understand that as a result of this waiver, I will receive only one meal period and it will be before the end of the 5th hour of work during each day of work, and I will be paid for all working time. I understand that if I am not provided my first meal period, then this waiver does not apply. I also understand that any day that I am scheduled to worked, or any day I do work in excess of twelve hours, this waiver does not apply and I am required to comply with the Hospital's meal period policy. I also understand that I, or the Hospital, may revoke this "Meal Period Waiver" at any time by providing at least one day's advance notice in writing of the decision to do so. This waiver will remain in effect until I, or the Hospital, exercises the option to revoke it.

I ACKNOWLEDGE THAT I HAVE READ THIS WAIVER, UNDERSTAND IT AND VOLUNTARILY AGREE TO ITS PROVISIONS.

SIGNATURE of EMPLOYEE:_____ DATE_____

PRINT NAME of EMPLOYEE: _____ DEPARTMENT:_____

HR REPRESENTATIVE:_____ DATE:_____

☐ I have chosen to opt out of meal waiver form.