2016-2017 Work Schedule / Group Form

Connecticut School Based Child Health Program

School District Name: _____ LEA: SB_____

Work Schedule/Group Name	Staff Start Time	Staff End Time

*Only one individual may be listed as the Time Study Coordinator for the RMTS.

District Time Study Coordinator Name: _____

Telephone Number: _____

Email Address: _____

Please email or fax completed forms to UMass directly at:
Schoolbasedclaiming@umassmed.edu or by fax to 508-856-7643