Cutting Edge Pediatric & Adult Therapy

900 Junction Dr.
Allen, TX 75013
P: (469) 675-3153
F: (469) 675-3154
info@ceptherapy.com

2501 N Walnut Creek Dr.
Mansfield, TX 76063
P: (817) 752-9662
F: (682) 400-8251
info_mansfield@ceptherapy.com

Therapist Workday Swap Agreement

This form serves as a formal agreement between two therapists to mutually swap scheduled working days. This is a full and complete day swap; both therapists agree to assume the full caseload and responsibilities of the other on the agreed date. Must be a swap with another therapist. Just having someone cover your shift would not qualify.

**Hybrid Salary Employees not eligible*

*Swapped dates need to be within 4 weeks of each other.

Agreement Terms & Disclaimer:

- Full Swap Commitment: This exchange is a complete swap of workdays. Each therapist must cover the other's schedule, including all originally assigned patient visits, without modifications.
- Patient Caseload Responsibility: Each therapist understands they will assume the patient caseload of the other without modification. If a therapist lacks the necessary skills for a specific patient, this swap will not be approved. (e.g., high-alert patient or a level 3 feeding patient, swapping therapist agrees to be prepared to see this patient on this day)
- No Administrative Adjustments: Admins will not adjust or reschedule any patients as part of this swap. If any office-driven cancellations or reschedules must occur, the therapist must submit a formal time-off request instead of using this swap form.
- No Responsibility for Caseload Differences: Cutting Edge is not responsible for differences in the number of patients, therapy type, or hours worked due to this swap. The therapists agree that the switch may result in a variance in patient volume or therapy intensity.
- Calling Out on Swapped Day: The agreed date becomes the provider's official workday. If absent, this absence will count toward the therapist's time-off balance as it would on a normal workday.

By signing below, each therapist affirms that they understand and agree to the terms listed above and to the change in workday listed below.

Requesting Therapist

Name: _____

Swap Details

Day of the Week: _____

Date: _____

Normal Working Hours: _____

Signature: _____

Date: _____

Swapping Therapist

Name: _____

Swap Details

Day of the Week: _____

Date: _____

Normal Working Hours: _____

Signature: _____

Date: _____

Submit the completed form to your location manager for approval.