TIME OFF REQUEST FORM

Care Professional Name: _____

Dates Requested: _____

Last day of work: _____

First day returning: _____

Total number of hours/days requested: _____

Total number of requested hours: _____ ☐Vacation ☐Paid Sick Leave ☐Unpaid

_____ _____

Care Professional Signature Date of Request

FOR INTERNAL USE ONLY

Hire Date: _____

Eligible for paid time off: ☐YES ☐NO

Vacation Hours Used: _____

Paid Sick Leave Hours Used: _____

Approved: YES NO

Reflected in Schedule: _____(Initial)

_____ _____

Supervisor Date