



TIME OFF REQUEST FORM

EMPLOYEE DETAILS			
Employee Name:			
Employee ID:		Department:	
Date:		Supervisor:	

TIME OFF DETAILS			
TYPE OF REQUEST			
<input type="checkbox"/>	Vacation	<input type="checkbox"/>	Jury Duty
<input type="checkbox"/>	Personal / Family Leave	<input type="checkbox"/>	Voting
<input type="checkbox"/>	Funeral/ Bereavement	<input type="checkbox"/>	Medical Leave
<input type="checkbox"/>	Maternity/Paternity Leave	<input type="checkbox"/>	Other
DATE(S) REQUESTED			
Start Date:	End Date:	Total Hours/Days:	
Duration:	<input type="checkbox"/> Full Day	<input type="checkbox"/> Half Day	<input type="checkbox"/> Other:
TYPE OF PAY			
<input type="checkbox"/> Unpaid Time Off	<input type="checkbox"/> Paid Time Off (Explain)		

EMPLOYEE ACKNOWLEDGEMENT	
By signing below, I understand that this request is subject to review and approval by my supervisor/manager. I acknowledge that time off is not guaranteed until I receive confirmation of approval.	
Employee Signature:	Date:

SUPERVISOR APPROVAL		
Request Approved:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
COMMENTS		
Supervisor Signature:	Date:	

ADMIN SIGNATURE	
	Date: