Original - Supervisor
Yellow - Accounting
Pink - Employee

Time Off Form

Name: _____

This form must be submitted at least two weeks prior to the requested time off to be considered for approval. There may be times when, even with adequate notice, requested time off will not be granted due to program needs or work coverage. If you will be taking time off due to a scheduled medical procedure, please fill this form out as far in advance as possible. This form should be turned in to your supervisor.

Time off requested:

☐ Paid*
☐ Unpaid
☐ Reason for time off: _____
_____

☐ Partial day; date and total hours _____
☐ One-half (1/2) day; date _____
☐ 1 day; date _____
☐ From _____
through _____

Direct Care Shifts Needing Coverage				
Consumer	Date	Time	Staff Covering Shift (Completed by Supervisor)	Coverage Not Needed by Family

Staff signature: _____ Date: _____

THIS SECTION COMPLETED BY ADMINISTRATIVE STAFF

Supervisor's signature: _____ Date: _____

If enough hours accrued, pay: _____ ☐ Approved ☐ Declined

* Employees will be paid only for time accrued. Approval for time off does not mean employees will be paid if they do not have enough hours.