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EMPLOYEE TIME-OFF REQUEST FORM

Employee Name	Today's Date	//
Employee Name	First Middle	
Date(s) Requested: from/	to/ Total: days	
☐ Partial Paid Sick Leave (l	Hours)	Illness
Please specify a number of hours of sid	ck leave if requested hours are less than 8 hours (1 day)	
☐ Paid Sick Leave (Day 1)	☐ Personal Illness ☐ Immediate Family Member ☐ Injury ☐ Doctor's Appointment	Illness
No verification is required. 1 day is equ	ual to 8 hours of sick leave.	
☐ Paid Sick Leave (Day 2-6)	☐ Personal Illness ☐ Immediate Family Member ☐ Injury ☐ Doctor's Appointment	Illness
	provide verification of the absence such as a medical doctor's note from the 00P-Paid Sick Leave) A maximum of 6 days (48 hours) for full-time employees are allowed for paid sick leave.	
☐ Vacation with Pay	(Regulation 3047.00R-Paid Vacation for Full-Time Employees) Five working days after 1 year of full-time employment. Ten working days after 4 years of full-time employment.	
☐ Vacation without Pay	Vacation without Pay must be approved by Supervisor at least 3 days prior to	vacation.
☐ Bereavement with Pay	(Regulation 3045R-Bereavement.) Maximum 3 days	
☐ Jury Duty:	(Regulation 3052 R-Jury Duty) Jury Summons and prospective Juror's questionnaire must be submitted upon request.	
☐ Compensation Time with Pay	Compensation Time with Pay must be approved by the President.	
	Please explain in detail.	
Other Request:		
☐ Other Request:		
☐ Other Request:		
	Date:/	