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 are out due to illness, please turn in this form the day after you return to work. If you will be taking sick 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.

Direct Care Staff:
- ☐ Paid* (Paid time is paid at base rate)
- ☐ Unpaid
- ☐ Reason for time off: ____________________
  ____

Administrative Staff:
- ☐ Vacation*
- ☐ Sick*
- ☐ Unpaid
- ☐ Other ______________________________

Time off requested:

- ☐ Partial day; date and total hours ________________________________
- ☐ 1 day; date _____________________________
- ☐ From _____________________________ to _____________________________

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

Received by: ____________________________________Date: ______________________

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.