TIME OFF REQUEST

Employee Name (Last / First / MI)

This is a request form only. It does not guarantee the requested time off will be granted.

Submit completed and signed *Time Off Request* form to your Supervisor/Manager with as much advance notice as possible to allow for review, approval and time for any scheduling arrangements that may be necessary.

TYPE OF TIME OFF

- ☐ Sick – Self**
- ☐ Sick – Immediate family member**
  - Relationship: _____
- ☐ Jury/Witness Duty *(attach summons)*
- ☐ Other: _____
- ☐ Vacation/PTO
- ☐ Bereavement
  - Relationship: _____
- ☐ Voting

LEAVE OF ABSENCE:

☐ Family Leave** ☐ Medical Leave** ☐ Military Leave ☐ Personal**

☐ Pregnancy** ☐ Other _____

** Absences of more than 3 consecutive days may qualify toward the Family Medical Leave Act (FMLA). FMLA is administered in accordance with State and Federal guidelines.

Contact Human Resources or EO Payroll Services, Inc. at (800) 933-6756 for more information or to request a Family Medical Leave form.

TIME OFF REQUESTED

Start Date: _____ Total Days Requested: _____

Return Date: _____ Total Hours Requested: _____

Employees on a leave of absence may be required to use their available paid time off benefit. Please contact EO Payroll Services, Inc. to confirm your employer's policy regarding time off and to coordinate benefits.

Employee Signature _____ Date _____

APPROVAL

Supervisor/Manager Name (printed) _____

Supervisor/Manager Signature _____ Date _____

Payroll: _____
Benefits: _____