TRINITY ASSISTANCE CORPORATION

TIME OFF REQUEST FORM

Employee Name: _____

Department: _____Manager: _____

List of Client/Family/Advocate Notified	Date of notification

Type of Time-Off Request:

☐ Sick	☐ Vacation	☐ Bereavement	☐ Time off Without Pay
☐ Military	☐ Jury Duty	☐ Maternity/ Paternity	☐ Other

Dates and/or Time for Time-Off:

From: _____ Through: _____

Reason for Time-Off:

You must submit requests for Time-Off, other than unforeseen sick leave, four weeks prior to the first day of your request.

_____

Employee Signature Date

☐ APPROVED

☐ DENIED

Comments:

_____

HR Signature Date