DEPARTMENT OF MEDICINE
TIME OFF REQUEST AND APPROVAL FORM

INSTRUCTIONS: Please complete the Time Off Request section of the form and submit it to your supervisor for review. Your supervisor will complete the Time Off Approval section to indicate whether your request was approved or needs to be rescheduled, and return a copy to you within a week of your submission.
SUBMIT A COPY OF THE APPROVED FORM TO: the Department of Medicine Payroll Office (PH 8W-890 • ph 5-2830 • fax 5-9549)

TIME OFF REQUEST

Employee Name: ____ SSN: ________________________

I would like to request time off for the following period(s):

Period	Start Date	End Date	Total # of Business Days	Purpose Code
1	/ /	/ /		
2	/ /	/ /		
3	/ /	/ /		
4	/ /	/ /		

PURPOSE:
V - Vacation
F - Personal
S - Illness
J - Jury Duty
D - Bereavement
M - Marriage
U - Unpaid Leave

Current available balance:

______________ **Vacation Days** ______________ **Personal Days**

____ Employee Signature

________________________ Date of Request

TIME OFF APPROVAL

Period	# of Days Approved w/ Pay	# of Days Approved w/out Pay	# of Days to Reschedule
1			
2			
3			
4			
Total			

____ Supervisor's Signature

________________________ Date of Approval

JAC:01/04