

## TIME OFF REQUEST FORM

### TO BE COMPLETED BY EMPLOYEE:

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Date: \_\_\_\_\_

Employee's Name: \_\_\_\_\_

Department/Title: \_\_\_\_\_

Time Off Request: \_\_\_\_\_ ☐ Days ☐ Hours

Beginning on: \_\_\_\_\_

Ending on: \_\_\_\_\_

### Reason for Request

- |  |  |
|--|--|
| <input type="checkbox"/> Paid time off   | <input type="checkbox"/> Compassionate leave |
| <input type="checkbox"/> Sick Leave      | <input type="checkbox"/> Home Office         |
| <input type="checkbox"/> Unpaid time off | <input type="checkbox"/> Maternity Leave     |
| <input type="checkbox"/> Vacation        | <input type="checkbox"/> Time off in lieu    |
| <input type="checkbox"/> Other _____     |  |

Date: \_\_\_\_\_

Employee's signature: \_\_\_\_\_

### TO BE COMPLETED BY EMPLOYER:

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### Employer's Decision

☐ Approved   ☐ Rejected

Date: \_\_\_\_\_

Employer's signature: \_\_\_\_\_