



**DEPARTMENT OF MEDICINE
TIME OFF REQUEST AND APPROVAL FORM**

INSTRUCTIONS: Complete this form to request time off.

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:**
B - Bereavement
C - Comp Time
F - Floating Holiday (*Personal Day*)
H - Holiday
J - Jury Duty
L - Unpaid Leave
S - Sick Day
V - Vacation Day

Current available balance:

 Vacation Days

 Personal Days

 Employee's 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