KAREN ANN QUINLAN HOSPICE

TIME OFF REQUEST

ATTENTION: PAYROLL
Fax No.: 973-383-6889

NAME: _____
(Please Print)

SUPERVISOR: _____

DAYS:	**SUN**	**MON**	**TUES**	**WED**	**THURS**	**FRI**	**SAT**	**SUN**	**MON**	**TUES**	**WED**	**THURS**	**FRI**	**SAT**
MONTH & DAY:														
TYPE OF BENEFIT:														

ENTER:

Fill in All Blanks:
Bereavement with "**B**"
Holiday with "H"
Sick with "**S**"
PTO with "**PTO**"

Employee Signature: _____ Date: _____

Office Only:

Date Received: _____

Days Requested:_____ Approved By: _____

Balance to Date: _____ Date: _____

Balance to Month End: _____

Approval of vacation time off is not a guarantee of payment. You will be paid only for benefit time earned.