

Imagine



Supported Living Services

## LEAVE REQUEST FORM

Employee Name: \_\_\_\_\_

Date of Request: \_\_\_\_\_

### Coverage for Time Off

Client Initials	Date & Shifts Covered (e.g. 7/02/18; 8am-5pm)	By Whom (printed name)	Signature of Sub (required)	Total Shifts	Total Hours

#### Type of Leave:

- Vacation (paid time off)
- Vacation Payout
- Unpaid time off
- Other (please explain):

#### Office Use Only:

Home Department: \_\_\_\_\_

Regular Rate: \_\_\_\_\_

Total Vacation Payout: \_\_\_\_\_

Office Admin Initials: \_\_\_\_\_

Payroll Period: \_\_\_\_\_

Total hours requested: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

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

Supervisor Signature: \_\_\_\_\_

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