

## TIME OFF

### Request Form

*Please PRINT using black ink*

Employee # \_\_\_\_\_

*For office use only*

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

Client Name: \_\_\_\_\_ County \_\_\_\_\_

Client Representative: \_\_\_\_\_ Daytime Phone # \_\_\_\_\_

Pay Period: Sun: \_\_\_\_\_ Sat: \_\_\_\_\_

(mm/dd/year)

(mm/dd/year)

You are eligible for Paid Time Off (PTO) if:

- ✓ You have worked 600 hours after July 1, 2015
- ✓ You have accrued eligible PTO hours; you will earn 1 PTO hour for every 52 hours worked beginning July 1, 2015.
- ✓ The Participant has approved to your use of PTO.
- ✓ You may use PTO when the participant is hospitalized.

*Refer to the Paid Time Off policy for more information regarding eligibility.*

☐ I am requesting use of \_\_\_\_\_ hours of PTO while the participant is in the hospital.  
*Signature of the Client/Representative is not required.*

☐ I am requesting to be paid for \_\_\_\_\_ hours of PTO.

Date(s) Requested: \_\_\_\_\_

Hourly Rate: \_\_\_\_\_

Total PTO Requested: \_\_\_\_\_

Signature by the Participant/Representative indicates approval of PTO. **Client/Representative is responsible for securing replacement care.**

Approval by Employee and the Client/Representative does not guarantee payment of time off.

**This PTO form must be submitted with your timecard for the period in which you are requesting PTO.**

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*Client/Representative Signature*

**FOR OFFICE USE ONLY:**

P.P.E. \_\_\_\_\_