Aging & Disabled Home Health Care
Affordable Home Care

TIME OFF REQUEST FORM

Employee Name: _____ Date: _____

DATE / TIME REQUESTING OFF : _____

TOTAL HOURS REQUESTED:

_____

ELIGIBLE FOR COMP TIME DUE TO: (Salary Staffs only)

_____
_____
_____
_____
_____

_____ _____

Employee Signature ***Date***

Approved By: _____ Date: _____

You must call the office and confirm the approval