



EMPLOYEE TIME OFF REQUEST

Date of Request: _____ Date Request received by HR: _____

Employee Name: _____ Title: _____

Department: _____ Supervisor: _____

Beginning: _____ Ending: _____ Returning: _____

TIME OFF DETAILS:

For each of the days that you are requesting to take off, please indicate the classification of that day.

Days Requested	Hours	Type of Request			
		<input type="checkbox"/> Bereavement	<input type="checkbox"/> Jury Duty	<input type="checkbox"/> Maternity/Paternity	<input type="checkbox"/> Military
		<input type="checkbox"/> Paid Vacation	<input type="checkbox"/> Sick Day	<input type="checkbox"/> Time Off/No Pay	<input type="checkbox"/> Other
		<input type="checkbox"/> Bereavement	<input type="checkbox"/> Jury Duty	<input type="checkbox"/> Maternity/Paternity	<input type="checkbox"/> Military
		<input type="checkbox"/> Paid Vacation	<input type="checkbox"/> Sick Day	<input type="checkbox"/> Time Off/No Pay	<input type="checkbox"/> Other
		<input type="checkbox"/> Bereavement	<input type="checkbox"/> Jury Duty	<input type="checkbox"/> Maternity/Paternity	<input type="checkbox"/> Military
		<input type="checkbox"/> Paid Vacation	<input type="checkbox"/> Sick Day	<input type="checkbox"/> Time Off/No Pay	<input type="checkbox"/> Other
		<input type="checkbox"/> Bereavement	<input type="checkbox"/> Jury Duty	<input type="checkbox"/> Maternity/Paternity	<input type="checkbox"/> Military
		<input type="checkbox"/> Paid Vacation	<input type="checkbox"/> Sick Day	<input type="checkbox"/> Time Off/No Pay	<input type="checkbox"/> Other

COMMENTS:

SIGNATURES:

Employee's Signature Date: _____

FOR OFFICE USE ONLY:

Approved Denied

Supervisor's Signature Date: _____

Church Administrator's Signature Date: _____

