Employee Days-Off Request Form

Please submit this form for approval at least five days in advance of your request days-off.

Date: _____

Employee Name: _____ Employee #: _____

Patient Name: _____

Dates Requested: _____/_____/_____ through _____/_____/_____

Returning: ____/____/_____

Total Number of Days Requested: _____

_____ _____ _____

Signature of Employee Print Name Here Date

Approval by:

_____ Date_____

Manager