Paid Time Off Request Form

Date of request: _____ Employee name: _____

Department: _____ Job title: _____

Vacation:

Start date: _____ End date: _____ Total hours: _____

Sick:

Start date: _____ End date: _____ Total hours: _____

Bereavement: (Up to three days due to a death in the immediate family/one day due to a death of all other family members)

Start date: _____ End date: _____ Total hours: _____

Jury duty:

Start date: _____ End date: _____ Total hours: _____

Parental leave: (2 week maximum)

Start date: _____ End date: _____ Total hours: _____

Other: _____

Start date: _____ End date: _____ Total hours: _____

This form should not be used to request Family and Medical Leave, Short-term disability or an accommodation under the Americans with Disabilities Act (ADA). Employees must consult with Human Resources to request leave under the FMLA, ADA, or STD program.

_____ _____ _____

Employee signature Supervisor signature Date

***File signed form in the employee's personnel folder**