

PAID 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 as of your hire date
- ✓ You have accrued eligible PTO hours; you will earn 1 PTO hour for every 40 hours worked
- ✓ 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. _____