RIGHT ACCORD
Health Staffing and Placement Services

TIME OFF REQUEST

Please Note: To allow time for Coverage –

- Submit 2 weeks PRIOR if requesting 1 to 5 days' time off
- Submit 1 month PRIOR if requesting more than 5 days' time off.
- Call the office ASAP @ 941- 917-1385 in case of an EMERGENCY.

Employee Name: _____ Date: _____

Type of Absence Requested: ☐ Vacation ☐ Jury Duty ☐ Bereavement

☐ Sick ☐ Time Off Without Pay

Other (specify:) _____

Dates of Absence: From (day/date/year) _____ returning on (day/date/year)

Reason for Absence:

_____

_____

Employee's Signature: _____ Date: _____

_____ Approved _____ Denied

Manager's Signature: _____ Date:_____

Comments:

_____