REQUEST FOR TIME OFF

EMPLOYEE NAME/NUMBER _____

DEALERSHIP _____

JOB TITLE/DEPT _____

PLEASE CIRCLE ONE OF THE BELOW:

VACATION PAID SICK LEAVE FMLA OTHER

BEGINNING DATE: _____

ENDING DATE: _____

TOTAL DAYS: _____ **OR**

TOTAL HOURS: _____ (allowed in 15 minute increments)

EMPLOYEE SIGNATURE: _____

SUPERVISOR ACKNOWLEDGMENT: _____