REQUEST FOR LEAVE

This form must be submitted 30 days prior to requested leave date.

DATE: _____

EMPLOYEE: _____

TYPE OF LEAVE: PTO _____ CME _____

The following leave days are requested:

_____

_____

IS COVERAGE REQUIRED BY DEPT. SUPERVISOR? YES ____ NO ___

Comments: _____

_____

SUPERVISOR APPROVAL: **(Print Name)** _____

(Signature) _____

Phone: _____ **Fax:** _____

RDSTAFFCO EMPLOYEE: **(Print Name)**

_____

DATE: _____ SIGNATURE: _____

APPROVED BY: _____ DATE: _____

KELFAS Services PROGRAM MANAGER

Email to info@kelfassservices.com

This request has not been approved until both and the on-site supervisor have signed this form. Unless law permits otherwise, leave requests must be submitted in advance to the Kelfas Program Manager. Approval for such requests are based on the business needs of the clinic and are granted at the discretion of the Corporation on a first come first serve basis. It is your responsibility to review your leave time availability prior to requesting time off as PTO must be used for any work absence. Requests for time off without pay are not allowed unless permitted by law or policy.