



VACATION REQUEST FORM

NAME: _____ COMPANY: _____

SUPERVISOR: _____ DATE: _____

DESTINATION: _____

FROM: _____ TO: _____
DATE DATE

HOURS OF ACCRUED VACATION TO BE USED: _____
(NUMBER OF WEEKDAYS X 8)

EMERGENCY CONTACT # _____
(NUMBER WHERE YOU CAN BE REACHED)

NAME OF **APPROVED** PERSON TO COVER YOUR WORKLOAD IN
ACCORDANCE WITH "THE PARTNER SYSTEM" FROM THE EMPLOYEE
HANDBOOK _____

HAVE YOU GIVEN YOUR SUPERVISOR ONE MONTH'S NOTICE? YES/ NO

REQUIRED SIGNATURES

SUPERVISOR- APPROVED/DENIED _____

DEPT. HEAD- APPROVED/DENIED _____

HR-RECORDED _____

PAYROLL- RECORDED _____

**NOTE: A COPY OF THIS COMPLETED FORM WILL BE RETURNED TO
YOU BEFORE TIME OFF IS GRANTED.**