Helping Hands Home Care
of Minnesota

2244 490th St
Northwood, IA 50459
Office: 507-993-7500
Fax: 888-691-4965
Email:
swright@helpingcareforyou.com

TIME OFF REQUEST

COMPLETE ONE FORM FOR EACH REQUESTED LEAVE

FILL OUT COMPLETELY AND SUBMIT TO THE OFFICE NO LATER THEN **2 WEEKS PRIOR TO NEEDING TIME OFF (unless Bereavement).**

NAME: _____DATE: _____

Staff to complete:	
Please state what time off is related to: Family Medical Leave __ Bereavement __ Leave without Pay __	
Start Date:	Return to work date:
For office use only:	
Office is approving the leave for the above dates?	Yes __ No __
Comments:	
Client affected by your request:	
Names and Schedule of Clients that will be affected: _____ _____ _____	
Clients that do not wish to have a Fill- in Staff: _____ _____	

Employee Signature: _____Date: _____

Supervisor Signature: _____Date: _____