Helping Hands Home Care of Minnesota
Office: 507-993-7500 Fax: 888-691-4965
Email: swright@helpingcareforyou.com

Forms also available on our website: www.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).**

Staff to complete: NAME: _____DATE: _____	
Please state what time off is related to: Family Medical Leave __ Bereavement __ Leave without Pay __ PTO ____	
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: _____ _____	
Complete by employee and turn in to the office by or before December 1 of each year to receive your PTO paid in full. **I _____ (EMPLOYEE NAME) WOULD LIKE TO REQUEST A FULL PAYMENT OF MY REMAINING PTO ON MY LAST PAYCHECK OF _____ (YEAR).**	

Employee Signature: _____Date: _____

Supervisor Signature: _____Date: _____