Waypoint
CENTRE *for* MENTAL HEALTH CARE
CENTRE *de* SOINS *de* SANTÉ MENTALE

Advancing Understanding.
Improving Lives.

Avancer la compréhension.
Améliorer la vie.

TIME OFF REQUEST FORM

EMPLOYEE INFORMATION

Program/ Unit/Dept		Skill:	
Name:	First Name	Last Name	
Employee Type		**Date Submitted mm/dd/yyyy**	

I have reviewed the status of my current benefit bank balances. With this request, I confirm by selecting this checkbox that I will not exceed the vacation time allocated for the calendar year

I confirm I do not have any activities, meeting(s), education, etc. prescheduled.

TIME OFF REQUEST INFORMATION

Date(s) Requested mm/dd/yyyy	Partial Days Hours requested	Vac-ation	Overtime Credits Taken	Stat Taken	Part-time unpaid vacation	Criteria Met/ Credits avail	Approved Or Denied (Manager)	QHR Updated
From: To:	e.g. 1500-1900					Yes No	Yes No	
From: To:						Yes No	Yes No	
From: To:						Yes No	Yes No	
MANAGER SIGNATURE				**DATE (mm/dd/yyyy):**				