Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE
Advancing Understanding. Improving Lives.
Avancer la compréhension. Améliorer la vie.

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TIME OFF REQUEST FORM

EMPLOYEE INFORMATION			
PROGRAM/ UNIT/DEPT		**Skill:**	
NAME:	First Name	Last Name	
Employee Type		**DATE Submitted**	

☐ 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	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: 3/20/25 To: 3/20/25	e.g. 1500-1900	☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐
From: 3/20/25 To: 3/20/25		☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐
From: 3/20/25 To: 3/20/25		☐	☐	☐	☐	☐ Yes ☐ No	☐ Yes ☐ No	☐
MANAGER SIGNATURE					**DATE:**			