

KAREN ANN QUINLAN HOSPICE

VACATION REQUEST:

Attention: PAYROLL

FAX NO.: 973-383-6889

NAME: _____

SUPERVISOR: _____

DAYS:	SUN.	MON.	TUES.	WED.	THURS.	FRI.	SAT.	SUN.	MON.	TUES.	WED.	THURS.	FRI.	SAT.
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MONTH & DAY:														
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TYPE OF BENEFIT:														
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ENTER:

FILL IN ALL BLANKS:

Bereavement with "B"

Excused Absence with "E/A"

Holiday with "H"

On Duty with "ON"

Personal with "P"

Vacation with "V"

Employee Signature: _____ Date: _____

Office Only:

Date Received: _____

Days Requested: _____

Approved By: _____

Balance to Date: _____

Date: _____

Balance to Month End: _____

Approval of vacation time is not a guarantee of payment. You will be paid only for benefit time earned.