QUALITY
TEMP STAFFING
MEDICAL STAFFING SPECIALISTS

Absence Request Form

Absence Information

Employee Name: _____ **Supervisor Name:** _____

Facility Name: _____ **Department:** _____

Type of Request (check that apply):

☐ Holiday ☐ Vacation ☐ Bereavement ☐ Time Off Without Pay

☐ Family Medical Leave ☐ Medical Appointment ☐ Maternity/Paternity

☐ Military ☐ Jury Duty ☐ Leave Early ☐ Late Arrival

☐ Other: _____

Date(s) of absence: From: _____ To: _____

What shift do you work? _____ **What days do you work?** _____

Do you have a replacement for your shift, If yes who? _____

***** You must submit requests for absences, other than sick leave, two weeks prior to the first day you will be absent. *****

Comments:

_____ _____

Employee Signature **Date**

OFFICE USE ONLY

In-house office staff comments:

_____

_____

☐ **Approved** ☐ **Rejected**

_____ _____

Office Manager's Signature **Date**