



Services, Inc.

# TIME OFF REQUEST FORM

EMPLOYEE: \_\_\_\_\_

DATE: \_\_\_/\_\_\_/\_\_\_

POSITION: \_\_\_\_\_

DATE FROM: \_\_\_/\_\_\_/\_\_\_

DATE THROUGH: \_\_\_/\_\_\_/\_\_\_

RETURN TO WORK: \_\_\_/\_\_\_/\_\_\_

### CHARGE TIME OFF TO:

- |   |   |
|---|---|
| <input type="checkbox"/> SICK/PERSONAL TIME | <input type="checkbox"/> BIRTHDAY                   |
| <input type="checkbox"/> VACATION           | <input type="checkbox"/> JURY DUTY                  |
| <input type="checkbox"/> BEREAVEMENT LEAVE  | <input type="checkbox"/> MILITARY LEAVE             |
| <input type="checkbox"/> UNPAID TIME OFF    | <input type="checkbox"/> FAMILY & MEDICAL LEAVE ACT |
| <input type="checkbox"/> OTHER _____        |   |

EXPLANATION: \_\_\_\_\_  
\_\_\_\_\_

*I understand that, unless I am on Family and Medical Leave (FMLA), I will be responsible for the full costs of my health insurance premiums, unless a different arrangement has been made. If I qualify for FMLA Leave, I may be invoiced for my health insurance premiums for the duration of eligible leave. If I was not invoiced while on FMLA leave, I authorize Bristol Management to bring my premium payments current by double-deducting from my paycheck, when I resume work. In addition, I authorize Bristol to make these same double-deductions from my paycheck when I resume work for premium payments (employee-employer) that were paid on my behalf during a non-FMLA leave. I understand that in certain situations this obligation to pay these premiums may allow Bristol Management, who has paid these premiums, to collect this money outside of the employment relationship.*

*Although reasonable effort will be made, I understand that no guarantee of reinstatement can be made for a Non-FMLA Medical or Personal Leave of Absence. I understand that if I do not return from my leave of absence at the expiration of this leave, unless an extension has been approved in advance, I have voluntarily resigned my employment.*

### TO BE COMPLETED BY SUPERVISOR PRIOR TO APPROVAL:

WILL A SUBSTITUTE BE NEEDED? YES \_\_\_\_\_ NO \_\_\_\_\_

IF SO, WHAT DAYS AND TIMES? \_\_\_\_\_

WHO HAVE YOU ARRANGED TO SUBSTITUTE? \_\_\_\_\_

IF THIS IS A PAID LEAVE, IS THE BOD AWARE OF THE ADDITIONAL COST? \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

SUPERVISOR'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

HUMAN RESOURCES APPROVAL: \_\_\_\_\_ DATE: \_\_\_\_\_