Charles R. Drew University
of Medicine and Science
A Private University with a Public Mission

TIME OFF REQUEST FORM

EMPLOYEE: This form should be completed and returned to your immediate supervisor at least thirty (30) days before the requested time off**.**

DO NOT USE THIS FORM IF YOU ARE REQUESTING TIME OFF FOR FMLA/CFRA, PREGNANCY LEAVE, DISABILITY LEAVE, OR PAID FAMILY LEAVE. PLEASE CONTACT HR FOR FURTHER INSTRUCTION.

EMPLOYEE NAME: ____ EMPLOYEE ID #: ________________________

DEPARTMENT: ____________________________________ SUPERVISOR: _______________________________________

REQUEST FOR: VACATION ☐ PERSONAL TIME OFF (PTO) ☐ OFF WITHOUT PAY ☐ OTHER ☐

OTHER: ____

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START DATE	RETURN DATE	NUMBER OF HOURS

ACCRUED BALANCE AS OF: ___________________ **VACATION**: ____________ **SICK**: ____________ **PTO**: ____________

COMMENTS:

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EMPLOYEE SIGNATURE**:** ____ DATE: _________________________

REQUEST APPROVED: YES ☐ NO ☐

AUTHORIZED SIGNATURE: ____ DATE: _________________________

ETORF REV: 06072018