HOME HEALTH CARE SOLUTIONS, LLC

PTO REQUEST FORM

EMPLOYEE NAME: (print)	DATE OF REQUEST:
APPROVED: _____________________	DENIED____________

REQUESTED DAYS/DATES OFF: (M-F)	# HOURS	#PAID	#UNPAID

Comments:____

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END OF YEAR BALANCES:

______ I elect to roll over 40 hours to the year 20___

____________________________________ ____________________________________

Employee Signature Date Manager Signature Date

Revised: Oct.2014