HARDIN COUNTY GENERAL HOSPITAL AND CLINIC

REQUEST FOR TIME OFF

EMPLOYEE NAME: _____ EMPLOYEE TITLE: _____

EMPLOYEE ID NUMBER: _____ DEPARTMENT: _____

REQUESTED DAY OFF OR FIRST DAY OF MULTI-DAY REQUEST: _____

LAST DAY OF MULTI-DAY REQUEST: _____ TOTAL HOURS REQUESTED: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

SUPERVISOR RECOMMENDATION: APPROVED DENIED
(CIRCLE ONE)

SUPERVISOR SIGNATURE: _____ DATE: _____

DEPARTMENT HEAD RECOMMENDATION: APPROVED DENIED
(CIRCLE ONE)

DEPARTMENT HEAD SIGNATURE: _____ DATE: _____

ADMINISTRATION DETERMINATION: APPROVED DENIED
(CIRCLE ONE)

ADMINSTRATION SIGNATURE: _____ DATE: _____