Autism Academy of Learning
Time Off Request Form

Employee:_____

Date:_____ Room Assigned:_____

I hereby request (check one): _____ Sick Time _____ Personal Day _____ Professional Day

____Day(s) of time off Date(s) _____/_____/20____ to _____/_____/20____

____Hours on _____/_____/20____ (between approx. hrs of ___:___ & ___:___)

☐ Medical Appointment

☐ Dental Appointment

☐ Optometrist Appointment

☐ Funeral – Relationship to Deceased _____

☐ Personal Day _____ Paid _____ Unpaid

☐ Professional Day

Is medical, dental, or optometrist appt. related to worker's comp claim? Yes_____ No_____

If YES, please state the name and address of the physician and the date of initial injury

Name of Physician:_____ Date of Initial Injury:_____

Claim #_____ Signature of Employee:_____
(To be completed by administrator)

Administrative Verification Only

Amount of accrued sick time available at time of request:		hours
Number of paid personal days available at time of request:		
Number of unpaid personal days available at time of request:		
Number of paid professional days available at time of request:		

_____ Approved

_____ Not Approved Reason:_____

Doctors note required? Yes_____ No_____

Administrator Signature:_____ Date:_____