

**Earned Paid Sick Time Request**

Employee Name (Please Print Clearly)		Date
Supervisor Name		
Beginning Date of Absence	End Date of Absence	Number of Hours Requested

**WRITTEN DOCUMENTATION IS REQUIRED FOR ANY ABSENCES OF 3 CONSECUTIVE DAYS OF MORE**

**PLEASE INDICATE BELOW THE SHIFT OR SHIFTS FOR WHICH YOU ARE REQUESTING PAID SICK TIME**

Date	Consumer Name	Begin Time	End Time	Hours
<b>TOTAL HOURS</b>				

By signing below, I acknowledge that I am requesting to use paid sick time for the shifts listed above, and the hours will be deducted from the number of paid sick time hours available to me. I further acknowledge that I may not use more than 40 hours of paid sick time in one year.

\_\_\_\_\_  
Employee Signature \_\_\_\_\_  
Date

<b>FOR OFFICE USE ONLY</b>		
Hours Available:	Denial Reason:	
Hours Requested:		
Hours Approved:		

