



ALLCARE
IN HOME CARE & ASSISTANCE
TIME-OFF REQUEST FORM

NAME: _____ **DATE:** ____ / ____ / ____

DATES REQUESTED

Date	Client	Shift Start Time	Shift End Time

Reason for Request:

- It is recommended that at least 7 days notice prior to request for time-off be given in order to schedule replacement appropriately & efficiently.
- This is a request form only. It DOES NOT guarantee the requested time will be granted.
- All field employees please return to this form to AllCare, LLC Management.

EMPLOYEE SIGNATURE: _____

Do Not Write Below This Line (For Office Use Only)

Request for time off is:

- Approved**
- Denied**

Reason for Denial: _____

Supervisor's Signature

Date