PREMIERE DENTAL

Employee Time-Off Request Form

Please complete and submit this form to your office manager at least two weeks prior to the requested date(s) for approval

Request Date **Employee Name (First and Last Name)**

Office Title/ Office Location

DAY	DATE	# OF HOURS REQUESTED	YOUR SCHEDULED HOURS	REASON FOR TIME OFF	COVERAGE
Monday					
Tuesday					
Wednesday					
Thursday					
Friday					
TOTAL HOURS REQUESTED PAID:			TOTAL HOURS REQUESTED UNPAID:		
EMPLOYEE SIGNATURE:			DATE:		

Provider/Office Manager to Fill in Below

Approved or Not Approved **Total Amount of Days/ Hours Requested by Employee**

If NOT Approved, Explain Why

Provider/Office Manager **Date**