Alternative Residential Services, Inc.
515 N. Neel St. Bldg. A Ste. 102 Kennewick, WA 99336
1150 Abadie St. Walla Walla, WA 99362

Request For Time Off

Date of Request: _______________**Employee Name**: ____________________________
HOUSE: _________________________ **SHIFT/POSITION**: ____________________

Day Requested: (list dates and times)
From: _________________________ To: ____________________________
Total Hours: ____________________ Total Days: _________________

Reason for Changing
( ) Vacation Time (mark **ONLY** if you have been here longer than 1 year): ___________________________
( ) Family Illness/Medical Appt. (Name): _______________________________________
( ) Family Death (Name): ____
( ) Personal Leave (mark **only** if you have P.L.) ____
( ) Other: ____

********************SHIFT COVERAGE ARRANGEMENTS********************
Signature of staff requesting time off: ____
Signature of staff covering shift: ____
***Specific* Coverage Arrangements (REQUIRED)**:
____

STAFF: The following are **REQUIRED** to be answered or your time off **WILL** be denied. (Circle answer)

1. **HAS THE PERSON COVERING YOUR SHIFT BEEN TRAINED TO WORK AT YOUR WORK SITE/SHIFT & IS DELEGATED FOR YOUR CLIENTS?**
   YES NO **(If NO, request is subject to immediate denial. Your coverage MUST have prior training at your work site/shift and MUST be delegated to give meds to your clients for time off approval)**

2. **DOES THIS TIME OFF REQUEST CAUSE OVERTIME? : YES NO**
   (If YES, request may be subject to immediate denial. Please resubmit with proper coverage/shift swap where no overtime is accrued by *any* staff member for time off approval)

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[For Administration Department Only]
Approved Date(s): _________________________ ( ) with pay ( ) without pay
Denied: ______ **Comments:** ____

____________________________________ ____________________
Administration Signature **Date**

Form Last Updated: 5/5/2016