# UNIVERSITY MEDICAL CENTER
## EMPLOYEE REQUEST FORM

This form is designed as a standard request form. It is to be used by the employee to inform the supervisor of department head of the employee's request for paid time off, leave of absence, transfer, or to give notice of resignation.

To:_____
*Department Head/Supervisor's Name*

Name:_____ Date:_____

Dept:_____ Position:_____

Shift:_____ Status:_____

**EMPLOYEE REQUEST**

1. ☐ PAID TIME OFF
   Effective Date: From _____ thru _____
   Number of PTO Days: _____

2. ☐ NON-PAID TIME OFF
   Effective Date: From _____ thru _____
   Number of non-paid Days: _____

3. ☐ EXTENDED ILLNESS
   Effective Date: From _____ thru _____
   Number of EI Days: _____

4. ☐ *LEAVE OF ABSENCE
   (refer to SPP 15-20)
   Effective Date: From _____ thru _____
   Paid Leave: _____Unpaid Leave: _____

5. ☐ *REQUEST FOR TRANSFER
   (refer to SPP 15-30)
   Effective Date: From _____ Unit _____
   Position: _____ Shift:_____

6. ☐ *RESIGNATION
   Effective Date: From _____
   (Resignation must be received two (2) weeks prior to effective date to qualify individual for terminal benefits if otherwise quailed.)

REASON FOR ACTION:

_____

_____

Requested by: ☐ Approved ☐ Disapproved

_____ _____
*Employee Signature* *Department Head/Supervisor Signature*

*Items so indicated must be explained under reason for action.