

TRAVIS COUNTY EMERGENCY SERVICES DISTRICT #1

EMPLOYEE REQUEST FOR TIME OFF

Name: _____ Last 4 SSN#: _____
 FIRST LAST

Request Leave to Begin: _____ On: _____ / _____ / _____
 TIME WEEK DAY MM DD YYYY

Leave to End: _____ On: _____ / _____ / _____
 TIME WEEK DAY MM DD YYYY

Hours Requested: _____

Type of Leave: _____

Reason: _____

EMPLOYEE NAME _____ MM / DD / YYYY

SUPERVISOR NAME _____ MM / DD / YYYY

