QUEST support

Our Mission To provide quality services which enhance the lives of people with disabilities.

Request for Time Off

Staff's Name: _____ Date: _____20 _____

Date	House	Start Time	End Time	Total Hours	Yes	No	Filled By

Please Read This

- This form must be received by the scheduling coordinators ***7 Business Days Prior*** to the time requested off for this form to be processed.
- Time off requested should be a minimum of three hours.
- Once this form is received by the scheduling coordinator it will be date stamped.
- **YOU** will need to call a scheduling coordinator ***3 Business Days Prior*** to your scheduled time off to verbally confirm that it has been filled.

By signing this form I understand that if my position cannot be filled I may be asked to cancel this time off which was requested.

Staff's Signature: _____ Date: _____

Scheduling Coordinator's: _____ Date: _____
Signature

Request for Time Off Verified: ☐ Date: _____

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