Fax Toll Free using 1-888-800-7336
Email to: Payroll@mymrci.org

PAID TIME OFF

Request Form

Please PRINT using black ink

Employee # ________________
For office use only

Employee Name: ____

Client Name: ____ County ________________________

Client Representative: ____________________________________ Daytime Phone # ________________

Pay Period: Sun: __________ Sat: __________
(mm/dd/year) (mm/dd/year)

You are eligible for Paid Time Off (PTO) if:

- ✔ You have accrued eligible PTO hours; you will earn 1 PTO hour for every 30 hours worked
- ✔ The Participant has approved to your use of PTO
- ✔ You may use PTO when the participant is hospitalized

Refer to the Paid Time Off policy for more information regarding eligibility.

☐ I am requesting use of______hours of PTO while the participant is in the hospital.
Signature of the Client/Representative is not required.

☐ I am requesting to be paid for______hours of PTO.

Date(s) Requested: ____________________________

Hourly Rate: _______________ **Total PTO Requested**: ____________

Signature by the Participant/Representative indicates approval of PTO. **Client/Representative is responsible for securing replacement care.**

Approval by Employee and the Client/Representative does not guarantee payment of time off.

This PTO form must be submitted with your timecard for the period in which you are requesting PTO.

______________________________ ______________________________
Employee Signature *Client/Representative Signature*

FOR OFFICE USE ONLY:

P.P.E. ________________