

**PODIATRY BILLING MASTERS REQUEST FOR
TIME OFF/VACATION**

With Pay

Without Pay

Vacation Day(s): From _____, _____ to _____, _____

Personal Day(s): From _____, _____ to _____, _____

Family/Bereavement Leave:
 From _____, _____ to _____, _____

Total Vacation Days: _____

Total Personal Days: _____

Total Bereavement Leave: _____

Employee Signature

Date requested leave

Doctor/Supervisor Approval Signature

Date Approved