ASPEN MEDICAL CENTER
URGENT CARE & PRIMARY CARE

REQUEST LEAVE FORM

Employee Name (Print): _____

DATES	TYPE OF LEAVE USING	HOURS USING	TRAVEL AMOUNT

Reason: _____

_____

Employee's Signature: _____ **Date:** _____ **Supervisor's Signature:** _____ **Date:** _____

PTO Balance-	
BPTO Balance-	
SICK Balance-	
Total Balance	

HR Signature: _____