Family Care Connections
Sick Time Request Form

Employee Name:		Supervisor's Name:
Person you were scheduled to work with:	Do they need a fill in during time off requested? o Yes o No	Service Being Provided: o Respite o Attendant Care o Habilitation
Sick Time Details (optional):		
Start Date:	Shift Time: _____AM or PM	Total Number of hours or days being requested (Max hours per day 8)
End Date:	End Time: _____AM or PM	
******If paid sick time is used 3 or more consecutive work days, a doctor's not or other documentation is required to return to work.**		

Employee Signature: _____ Date: _____

*Office Use Only:

Approved: _____ Entered: _____