

L.I. HEAD START CHILD DEVELOPMENT SERVICES, INC.

TIME OFF PLAN

Date: _____

Name: _____

Title: _____

Site: _____

ACCUMULATED HOURS		TIME OFF SCHEDULE	
Date _____	Hours _____	Date	Hours to be Taken
Reason _____		_____	_____
Date _____	Hours _____	_____	_____
Reason _____		_____	_____
Date _____	Hours _____	_____	_____
Reason _____		_____	_____

The total of accumulated hours must equal the total of hours taken Attach a copy of the time Card for the period from which time was accrued.

Employee's Signature Date

Supervisor's Signature Date

Signature Date
(Chief Executive Officer)

Received by (Payroll) Date

Note: It is required that time off must be scheduled within the nearest full pay period following the accumulation of hours.