Illinois Conference of Seventh-day Adventists

VACATION REQUEST SALARY (OFFICE)

NAME ______________________________________ DATE ___________________

DATES REQUESTED*: FROM __________________ THROUGH ___________________

**** Per Illinois Conference Policy (L-90), please submit at least two weeks in advance of the intended vacation***

EMERGENCY CONTACT INFORMATION

Name ____

Address ____

City ____________________________ State ______ Zip Code ____________________

Phone - Home ______________________________ Mobile ______________________

FOR OFFICE USE ONLY

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YEARS OF SERVICE	1-4	5-9	10+		DAYS	TOTAL
Days Accruable	14	21	28		_________	__________
CarryOver from last year				+	_________	__________
Used to Date				-	_________	__________
MONTH				-	_________	

S _____ _____ _____ _____ _____ _____

M _____ _____ _____ _____ _____ _____

T _____ _____ _____ _____ _____ _____

W _____ _____ _____ _____ _____ _____

T _____ _____ _____ _____ _____ _____

F _____ _____ _____ _____ _____ _____

SA _____ _____ _____ _____ _____ _____

APPROVED
Dept Signature:
____

APPROVED
Admin. Signature:
____