



Growing Abilities  
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Jennifer ☐  
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## Time off Request Form

Provider: \_\_\_\_\_  
(Please Print Full Name)

Today's Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Case Manager: \_\_\_\_\_

Initial Request Made on \_\_\_\_\_ Via: ☐ Phone ☐ Verbal ☐ Text ☐ Email ☐ Paper  
(Date)

☐ Personal Time ☐ Sick Time (PST-Paid) ☐ Sick Time (unpaid)

**For Earned Paid Sick Time Use Only**

☐ I plan to use \_\_\_\_\_ hours of Earned Paid Sick Time (if available).

If Absent 3 or more days was documentation given? ☐ Yes ☐ No

Type of Documentation: ☐ Medical ☐ Legal ☐ Other: \_\_\_\_\_

Please be advised that I will require the following dates off:

\_\_\_\_\_  
\_\_\_\_\_

Reason for time off:

\_\_\_\_\_  
\_\_\_\_\_

I have made the following arrangements for coverage during my time off:

\_\_\_\_\_  
\_\_\_\_\_

I will require assistance finding coverage for the following members (times and days):

\_\_\_\_\_  
\_\_\_\_\_

Request: APPROVED DENIED

Case Manager comments:

\_\_\_\_\_  
\_\_\_\_\_

Provider (Signature): \_\_\_\_\_ Date Signed: \_\_\_\_\_

Case Manager: \_\_\_\_\_ Date Signed: \_\_\_\_\_  
(Print) (Signature)

Received by: \_\_\_\_\_ Date Received: \_\_\_\_\_