

Please submit this form for approval at least four weeks in advance of your preferred vacation

Vacation Request Form

dates.

Date: ______

Employee Name: ______

Title: _____

Vacation Dates Requested: ____/___/ through ____/___/

Returning to Work: ____/____

Total Number of Days Requested: ______

Date_____

Signature of Employee

Approval:

_____ Date_____

Manager

Excel Health Care Services Inc. Phone: 301-306-8280 Fax: 301-459-2400 Page 1