



HOME HEALTH AGENCY
 1707 L Street. NW Suite 900
 Washington, DC 20036
 Tel 202-829-1111
 Fax 202-829-9192

**HHA/PCA
 Leave Request Form**

TO: _____
 (Supervisor)

Today's Date: _____

FROM: _____
 (Employee Name – Print)

 (Client's Name-Print)

Employee Phone No. _____

Client's phone No _____

Email Address: _____

Service Hours & Time _____

First Day of leave: _____

Last Day of leave: _____

Hours Total: _____

Type of leave requested:

Approved Yes No Date: _____

- Safe/sick leave benefit for self (will need doctor's note for leave of three or more days, subject to accrual)
- Safe/sick leave benefit for family member (will need doctor's note for leave of three or more days, subject to accrual)
- Other (explain): _____

Is this leave request related to an emergency?

- Yes (if yes, please provide an explanation for not being able to provide sufficient notice to HMI)
- No

All requests must be submitted at least ten (10) days prior to the requested leave date(s). If emergency leave is requested, you must attach a written explanation for the emergency. For frequent emergency leave requests, additional documentation may be requested. Last minute (same day) call-outs are not acceptable unless there are extraordinary circumstances.

 Employee's Signature

 Date

 Supervisor's Signature

 Date

Notes (for office/employer use):

