



Illinois Conference of Seventh-day
Adventists

VACATION REQUEST - Office

NAME _____ DATE _____

DATES REQUESTED: FROM _____ TO _____

EMERGENCY CONTACT INFORMATION

Name _____

Address _____

City _____ State _____ Zip Code _____

Email: _____ Phone: _____

FOR OFFICE USE ONLY

YEARS OF SERVICE	1-4	5-9	10+		DAYS	TOTAL
Days Accruable	8	12	16		_____	_____
Carryover from last year				+	_____	_____
Used to Date				-	_____	_____
MONTH _____				-	_____	<input style="border: 1px solid black; width: 50px; height: 20px;" type="text"/>

S _____
M _____
T _____
W _____
T _____
F _____
SA _____

APPROVED
Admin. Signature:
