Email to: payroll@MyMRCI.org
Fax to: 1-888-800-7336

PAID TIME OFF
Request Form

MRCI CLIENT DIRECTED SERVICES

Employee Name: _____

Client Name: _____

Client Representative: _____

Pay Period: Sun:_____ Sat:_____
(mm/dd/year) *(mm/dd/year)*

You are eligible for Paid Time Off (PTO) if:

- ✔ You have accrued eligible PTO hours; you will earn 1 PTO hour for every 30 hours worked
- ✔ The Participant has approved to your use of PTO
- ✔ You may use PTO when the participant is hospitalized

Refer to the Paid Time Off policy for more information regarding eligibility.

☐ I am requesting use of_____hours of PTO while the participant is in the hospital.
Signature of the Client/Representative is not required.

☐ I am requesting to be paid for_____hours of PTO

Date(s) Requested: _____

Hourly Rate:_____ **Total PTO Requested: _____**

Signature by the Participant/Representative indicates approval of PTO. **Client/Representative is responsible for securing replacement care.**

Approval by Employee and the Client/Representative does not guarantee payment of time off.

This PTO form must be submitted with your timecard for the period in which you are requesting PTO.

_____ _____
Employee Signature *Client/Representative Signature*

_____ _____
Date *Date*