FAXTON ST. LUKE'S HEALTHCARE
PAYROLL EDIT AUTHORIZATION
REQUEST FORM

EMPLOYEE NAME: _____

EMPLOYEE NUMBER: _____

DEPARTMENT: _____

PAY PERIOD END DATE: _____

REQUESTED PAID BENEFIT DAYS OFF

SCHEDULED PAID TIME OFF (PTO):	Date (s) _____	Total Hours _____
EMERGENCY LEAVE (EPTO):	Date (s) _____	Total Hours _____
UNSCHEDULED LEAVE (UPTO):	Date (s) _____	Total Hours _____
SICK TIME (1st 2 DAYS) (UPTO):	Date (s) _____	Total Hours _____
EXTENDED SICK (ESLB):	Date (s) _____	Total Hours _____
JURY DUTY:	Date (s) _____	Total Hours _____
BEREAVEMENT:	Date (s) _____	Relationship _____
LEAVE WITHOUT PAY:	Date (s) _____	

OTHER (NO BADGE, OFFSITE MEETING, SEMINAR ETC.) Please explain:
_____

Date (s) _____ In Punch _____ am ☐ pm ☐ Out Punch _____am ☐ pm ☐

Date (s) _____ In Punch _____ am ☐ pm ☐ Out Punch _____am ☐ pm ☐

Date (s) _____ In Punch _____ am ☐ pm ☐ Out Punch _____am ☐ pm ☐

Missed Lunch Period ☐ Date (s) _____ Reason: _____

ON CALL

Length of time in which you served in an On-Call status?

From: Time_____am ☐ pm ☐ Date_____
To: Time_____am ☐ pm ☐ Date_____

Total On-Call Hours: _____

EMPLOYEE SIGNATURE:_____ DATE: _____

SUPERVISOR'S APPROVAL:_____ DATE: _____