CCSD Health Aide Time-Off Request Form

I UNDERSTAND THIS REQUEST IS SUBJECT TO APPROVAL BY THE NURSING DEPARTMENT AND SCHOOL PRINCIPAL.

Employee's Name: **Date:** **Requested Dates Off:**

Text or Call for Coverage

☐ Erin Brand (801) 628-1771

Notify for Approval

☐ Principal

Share this form by Email

☐ Erin Brand erin.brand@ccsdut.org

☐ Karen Peterson karen.peterson@ccsdut.org

☐ Heidi Bowler heidi.bowler@ccsdut.org

☐ Principal

This section to be completed by Nursing Department

☐ APPROVED ☐ REJECTED

Covered By

☐ FLOAT RN ☐ SCHOOL OFFICE STAFF ☐ PARENT ☐ NURSING DEPT

Completed

☐ CONTACT HEALTH AIDE ☐ CONTACT SCHOOL ☐ ENTERED ON CALENDAR

Reason for Request

☐ Family Reasons ☐ Funeral/Bereavement ☐ Illness/Medical

☐ Personal Leave ☐ Vacation ☐ Other (State reason):

Nurses Signature: **Date:**