HOLIDAY REQUEST FORM

Pharmacy Stamp

HOLIDAY YEAR: _____

EMPLOYEE NAME: _____

BRANCH NAME: _____

HOLIDAYS REQUESTED:

FROM _____(day) _____(date)

TO _____ (day) _____(date) Inclusive

TOTAL NUMBER OF WORKING DAYS _____

SIGNED: _____

DATE: _____

APPROVAL OF MANAGER

HOLIDAYS TAKEN _____

HOLIDAYS REMAINING _____

SIGNED _____

DATE _____

FOR OFFICE USE ONLY