LOS ANGELES COUNTY DEPARTMENT OF HEALTH SERVICES

ADVANCED PRACTICE REGRISTERED NURSE
CONTINUING MEDICAL EDUCATION
REQUEST FOR TIME OFF

(PLEASE PRINT LEGIBLY)

Part I. Employee Information

Employee's LAST Name: ____

Employee's FIRST Name: ____

WARD: ______________________ SERVICE: ___________________ DEPARTMENT: _____________________

EMPLOYEE #: ________________ ITEM #: ____________________ LICENSE #: ________________________

COST CENTER #: __________________________ CONTINUOUS SERVICE DATE: ____________________

CLASS/PROGRAM NAME: ___________________________________ DAY TIME PHONE#: ____________________

CLASS/PROGRAM DATES: ______________ TIME: ___________ PLACE: ______________ UNITS: ________

TIME REQUEST: ACTUAL: ______________________ /REQUESTED: ______________________

APPLICANT'S SIGNATURE:

____

Part II: Immediate Supervisor Approval

This employee has been granted:

Past Fiscal Year: __________ hours/$ __________ Current Fiscal Year: __________ hours/$ __________

APPROVED: ______

DENIED: ______ Reason: ____

COMMENTS:

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IMMEDIATE SUPERVISOR'S SIGNATURE: _____________________________ DATE: _____________________________