

VACATION REQUEST

DODDRIDGE COUNTY BOARD OF EDUCATION

12 MONTH EMPLOYEES

Date _____

TO: _____ Supervisor

FROM: _____ Employee Social Security No _____

I wish to request the following dates for my vacation:

Month	Vacation Dates
_____	_____
_____	_____

Total Days Requested _____

I understand that should I become ill or suffer an injury I am to report my condition to my immediate supervisor within 72 hours to claim personal leave rather than vacation time.

I further understand that my vacation time must be used between July 1 and June 30 and that I may not be paid additional pay for unused vacation time without the approval of the Superintendent and the Board of Education, and then only in the event of an illness, injury or catastrophe.

EMPLOYEE _____
(Signature)

APPROVED BY: _____ DATE: _____