HOUSTON Methodist LEADING MEDICINE

Paid Time Off (PTO) Request

Last Name (Please print):	First Name:		Middle Initial:
Department Name:	Department ID:	Date:	
Please indicate number of hours requested:			
Scheduled PTO will start on:	Employee will return on:		
Management Approval (must be MG03 or higher): Approved: ☐ Not Approved: ☐			
If not approved, please provide reasons for denying request:			
Manager Name (please print)			
Manager Signature:			
Should my employment be terminated with a negative PTO Balance, I hereby authorize the Payroll Department to withhold the value of the negative PTO Balance from my final paycheck.			
Employee Signature:			

Completed forms should be kept by employee.