



MARION EYE CENTER & Optical

PHYSICIAN'S TIME OFF CHANGE CORRECTION

NAME _____
(PLEASE USE ONE FORM PER DATE CHANGE)

PREVIOUSLY APPROVED DATE, TIME, & DESIGNATION:

Fill in the original information for your TIME-OFF request:

Pre-Authorized Date: _____ Original Hours: _____

Pre-Authorized Payroll Designation:

VACATION WITH PAY VACATION WITHOUT PAY PLEASE USE SATURDAY TIME CONTINUING EDUCATION

NEW (Change) REQUEST:

Fill only the portions which pertain to your changing circumstance:

DATE CHANGE _____ HOURS TAKEN CHANGE: _____

Change Payroll designation to:

VACATION WITH PAY VACATION WITHOUT PAY PLEASE USE SATURDAY TIME CONTINUING EDUCATION

Comments: _____

DOCTOR'S SIGNATURE _____

DATE _____