

DEPARTMENT OF MEDICINE MONTHLY TIME OFF TRACKING FORM

MEDICINE PAYROLL OFFICE
PH 8 West, Rm 890
Phone 305-2830
Fax 305-9549

INSTRUCTIONS: Complete the grid to indicate any time using the appropriate codes at the bottom of the form. Be sure to complete beginning and ending balances as well as time used and accrued. **Original signed forms must be submitted to the Medicine Payroll Office by the first Friday of the following month.**

Employee Name: _____ SSN: _____

Supervisor Name: _____ Month/Year: _____

Vacation Beginning Balance _____

Floating Holidays Beginning Balance _____

1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Vacation Days Used _____

Floating Holidays Used _____

Vacation Days Accrued _____

Floating Holidays Accrued _____

Vacation Ending Balance _____

Floating Holidays Ending Balance _____

Employee Signature _____ Date _____

Supervisor Signature _____ Date _____

Time Off Codes:
B - Bereavement; **C** - Comp Time; **F** - Floating Holiday; **H** - Holiday; **J** - Jury Duty; **L** - Unpaid Leave; **S** - Sick Day; **V** - Vacation Day