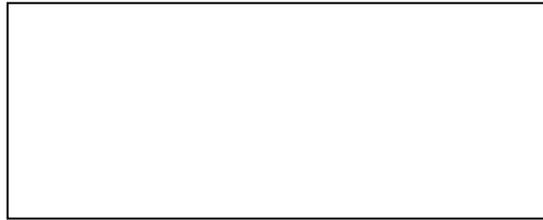


HOLIDAY REQUEST FORM



Pharmacy Stamp

HOLIDAY YEAR: _____

EMPLOYEE NAME: _____

BRANCH NAME: _____

HOLIDAYS REQUESTED:

FROM _____ (day) _____ (date)

TO _____ (day) _____ (date) Inclusive

TOTAL NUMBER OF WORKING DAYS _____

SIGNED: _____

DATE: _____

APPROVAL OF MANAGER

HOLIDAYS TAKEN _____

HOLIDAYS REMAINING _____

SIGNED _____

DATE _____

**FOR
OFFICE
USE
ONLY**