HealthMax
Home Health Care

# Sick & Safe Leave

Request Form

Caregiver name: ______________________________________________

Dates and hours:

| Date: | Hours requesting: | Client name: | Service: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

By signing this form, I certify that I am requesting paid sick and safe leave for one of the reasons listed in the HealthMax Sick & Safe Leave Policy, that I may be asked to provide reasonable documentation for leave lasting more than three days, and that paid leave may be denied if the terms of the policy have not been followed.

Caregiver signature: ________________________________ Date: _______________________________________

Office Use Only Below This Line

---

Office: ☐ Twin Cities ☐ St. Louis Park ☐ Coon Rapids ☐ St. Cloud

Leave approved: ☐ Yes ☐ No By (Manager name): ________________________________________

If no, reason for denial:

Manager Signature: _________________________________ Date: ___________________________________