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| --- | --- |
| Personal Information | |
| Employee Name: |  |
| Phone Number: |  |
| Date: |  |
|  | |
| Facility Information | |
| Facility Name: |  |
| Manager: |  |
|  | |
| Shift Cancellation | |
| Shift (Specify which Shift was Cancelled): |  |
| Day/Time Shift Cancellation Occurred: |  |
| Reason for Cancellation: |  |
| Additional Shifts Offered by the Facility: |  |
| Other Comments: |  |
|  | |
| Supporting Documentation | |

This form must be submitted within fourteen days from the date of cancellation and must include supporting documentation (screenshot, text message, email, etc) regarding the reason for cancellation **OR** include manager approval below.

Manager Approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_