St. Clair County Community Mental Health Authority

Vacation Cap Variance Request

STAFF NAME: _____ DATE: _____

Reasons for variance request:

☐ Vacation requested and denied due to project deadlines (See attached Leave Time Request)
☐ Vacation requested and denied due to other staff vacation schedules (See attached Leave Time Request)
☐ Union contract implementation with increased vacation allotments
☐ Other _____

Number of vacation hours requested to carry forward _____

Approval of this request will result in my vacation bank going to approximately _____ hours.
My anniversary date is: _____ . I plan to use my carry forward of vacation hours by the following date:_____
(Not to exceed six months from date of request.)

I understand that if I fail to use my excess time within the previously specified time frame, I will lose it.

Staff Signature:_____ Date: _____

Supervisor Review: ☐ Recommend Approval ☐ Denial (Explanation) _____
_____

Supervisor Signature:_____ Date: _____

Division Director Review: ☐ Recommend Approval ☐ Denial (Explanation) _____
_____

Division Director Signature: _____ Date: _____

Applicable Assoc. Director Review: ☐ Approved ☐ Denied

Associate Director Signature:_____ Date:_____

NOTE: *The current contract allows the following:*
The Agency shall have exclusive authority to waive the maximum limit for a reasonable period not to exceed six (6) months in the event an employee is unable to take vacation time. The waiver of the maximum limit will not be arbitrarily withheld. In the event the employee fails to schedule vacation usage that would bring them back into compliance during the variance period, the days over the maximum will be forfeited.

cc: Chief Executive Officer
Chief Operating Officer
Supervisor
Staff
Payroll Department
Personnel File