### Faculty Out of Office & Schedule change Request Form

**University of Louisville Department of Medicine**

Requests for Time Off should be made at least 90 days in advance

#### Step 1: Faculty Member’s Name (Last, First):

____________________________________

**Division:**

____________________________________

**Faculty Signature:**

**Date(s) Requested Out of Office:**

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**Type of Request (check one):**

- ______Vacation
- ______CME/Professional
- ______Military
- ______Sick
- ______Personal
- ______Bereavement
- ______Other

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**Describe Details of Request & Reason for Absence (include meeting name, date(s), location, your role, etc.):**

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**Clinical Locations Affected (Please check all that are affected):**

<table>
<thead>
<tr>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCOC Ste. 310</td>
</tr>
<tr>
<td>HCOC Ste. 370</td>
</tr>
<tr>
<td>HCOC Ste. 690</td>
</tr>
<tr>
<td>Sleep</td>
</tr>
<tr>
<td>AIM</td>
</tr>
<tr>
<td>550 Clinic</td>
</tr>
<tr>
<td>Indiana</td>
</tr>
<tr>
<td>Springs</td>
</tr>
<tr>
<td>Motility</td>
</tr>
<tr>
<td>CHF/ BCC</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

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**How many patients impacted?**

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**Describe your plan to accommodate:**

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**Patients/Clinic Coverage:**

- ____________________________
  - Signature
  - Date

- ____________________________
  - Signature of M.D Covering
  - Date

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**Make Up Dates: (Not required for vacation days used.):**

- ____________________________
  - Signature
  - Date

- ____________________________
  - Signature of M.D Covering
  - Date

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**Step 2: Approved by Division Director:**

- ____________________________
  - Signature
  - Date

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**Step 3: Approved by Chairman: (If < 30 Days):**

- ____________________________
  - Signature
  - Date

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Revised 03/21/18 CW