UNIVERSITY OF
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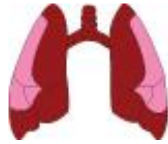
SCHOOL OF MEDICINE



Pulmonary, Critical Care & Sleep Disorders Medicine

University of Louisville Physicians

FACULTY REQUEST FOR LEAVE

FACULTY NAME: ____

BEGINNING DATE ______________________ **ENDING DATE** ________________________________

RETURN TO WORK DATE ____

TYPE OF LEAVE REQUESTED:

(This form covers all days of each month including holidays and weekends)

VACATION

OTHER:____

CME MEETING

Non-CME Meeting

Dates ______________________________

Conference Type: _________________________________

Location ____

Vacation Used: ______

CME/Non CME Days Used ___________

Vacation Days Remaining _______

CME/Non CME Days Remaining ________

COVERAGE: (Must be arranged by physicians)

Rotation _________________ **Signature of Covering Physician**_______________________________________

Clinic _________________ **Paperwork Submitted Yes No**

Make-up Clinic Date: ____

Comments: ____

Faculty Signature: ____ **Date** _____________________________

Approved by: ____ **Date** ______________________________

Mohamed Saad, MD, Chief Pulmonary, Critical Care and Sleep Disorders

****Any changes in this request after submission of this form should be validated with a new copy of this form.**

- **This form should be completed/approved at least 15 days before month of leave requested.**