FACULTY REQUEST FOR LEAVE

FACULTY NAME: ________________________________

DATE OF REQUEST TO BEGIN: ________________ DATE OF REQUEST TO END: ________________

TYPE OF LEAVE REQUESTED:
(This form covers all days of each month including holidays and weekends)

VACATION
SICK
CME/EDUCATIONAL MEETING:
  Dates: ____________________________ Conference Type: ____________________________
  City/State: ____________________________

Vacation Used: __________
Vacation Days Remaining: __________

COVERAGE: (Must be arranged by physicians)

Rotation ______
Night Call ______
Clinic ______
Weekend ______
Holiday ______

Signature of Covering Physician: ____________________________

Make-Up
Clinic Date: ____________________________

Comments: ____________________________

Faculty Signature: ____________________________ Date: __________

APPROVED: ____________________________ Date: __________

Jesse Roman, M.D., Chairman of Medicine

*Return this form to Debbie at least 15 days before month of leave requested.

**ANY CHANGES TO THE SCHEDULE AFTER SUBMISSION OF THE FORM SHOULD BE VALIDATED WITH A NEW COPY OF THIS FORM.