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.