# RESIDENT LEAVE REQUEST

*DEPARTMENT OF INTERNAL MEDICINE*

***No travel or other plans should be made prior to receiving approval.***

**Resident Name:** _____ **PGY Level:** _____ **Date Submitted:** _____

*Print Name*

**ROTATION:** _____ **ATTENDING:** _____

***REQUESTING LEAVE***

***from:*** _____ ***to:*** _____

*Date* *Date*

_____

*Resident Signature*

| Total # of days requested: | | | |
|---|---|---|---|
| VAC | SICK | ADMIN | EDUC |
| | | | |

***Will Resident be present at least 3 weeks in order to get credit for this rotation?***

**TYPE OF LEAVE:**

**Vacation** ☐ **Educational** ☐

**Sick** ☐ **Administrative** ☐

***Please complete box below if requesting Educ. or Admin. Leave.**

**Destination:** _____

**Date/Time of Departure:** _____

***CLINIC RESPONSIBILITIES***

**Is there a conflict with Clinic responsibilities?**

**YES** ☐ If YES, resident must secure coverage and complete below.

Coverage by: _____ _____ _____

*Print name of staff covering* *Signature of staff covering* *Date*

**NO** ☐ Clinic was cancelled _____ _____

*Clinica Manager or Assigned Clinic Staff Signature* *Date*

**COMMENTS:** _____

***WARD, POST-CALL CLINIC, BACK-UP AND/OR OTHER RESPONSIBILITIES***

**Is there a conflict with Weekend Call, Post Call Clinic, Backup or any other responsibilities?**

**YES** ☐ If YES, resident must secure coverage and complete below.

Coverage by: _____ _____ _____

*Print name of staff covering* *Signature of staff covering* *Date*

**NO** ☐ _____ _____

*Chief Resident Signature* *Date*

_____ _____

*Chief Resident Signature* *Date*

**COMMENTS:** _____

**Chief Resident:** _____ **Date:** _____

*(Signature)*

**Clinic Manager:** _____ **Date:** _____

*(Signature)*

**Attending Faculty:** _____ **Date:** _____

*(Signature)*

**Prog. Dir. or Assoc. Prog. Dir :** _____ **Date:** _____

*(Signature)*

☐ **LEAVE REQUEST - NOT APPROVED**

_____ _____ _____

*Print Name* *Signature* *Date*

**COMMENTS:** _____

*Revised: 7/25/08*