

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 or Stamp Name

ROTATION: _____ ATTENDING: _____

REQUESTING LEAVE:
from _____ to _____
Date Date

Total # of days requested:			
VAC	SICK	ADMIN	EDUC

Resident Signature

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: _____
STAFF COVERING (Print or Stamp) 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: _____
STAFF COVERING (Print or Stamp) Signature of staff covering Date

NO _____
Chief Resident Signature & Stamp Date

Chief Resident Signature & Stamp Date

COMMENTS: _____

Chief Resident: _____ Date: _____
(Signature & Stamp)

Clinic Manager: _____ Date: _____
(Signature & Stamp)

Attending: _____ Date: _____
(Signature & Stamp)

Prog. Dir. _____
or
Assoc. Prog. Dir: _____ Date: _____
(Signature & Stamp)

LEAVE REQUEST - NOT APPROVED by _____

(Signature & Stamp) Date