

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