



DIAGNOSTIC RADIOLOGY RESIDENT LEAVE REQUEST FORM

Please complete this form and have it signed by the appropriate attending radiologist at your rotating hospital, then return the signed form to Rhonda Kaye Tuttle (Fax #: 813-974-3482).

Name: _____ Date of Request: ___/___/___

Leave Dates Requested (maximum of 5 per rotation):

1. ___/___/___ 2. ___/___/___ 3. ___/___/___ 4. ___/___/___ 5. ___/___/___

Type of Leave Requested: Annual
 Conference (approved departmental activity)
 Sick

Rotation: _____ Institution: All Children’s Hospital
 Bay Pines VA Hospital
 Moffitt Cancer Center
 James A. Haley VA Hospital
 Tampa General Hospital

Special Leave Request:

If greater than one week (5 working days) of leave is requested during a four week rotation, if another person has already requested leave for the dates needed, or if the leave is requested on short notice, please provide the reason(s) the above dates are needed:

For Departmental Use

Approval:

- Approved _____ ___/___/___
- Denied* Rotation Director or Hospital Education Director Date
- Approved _____ ___/___/___
- Denied* Residency Program Coordinator Date

Special Leave Request:

- Approved _____ ___/___/___
- Denied* Residency Program Director Date

***Comments:**