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 Candice Kunkle (Fax # 813-250-2547 or ckunkle1@health.usf.edu).

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
- ☐ James A. Haley VAH
- ☐ Moffitt Cancer Center
- ☐ 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: