RESIDENT LEAVE REQUEST FORM

Dept. of Orthopaedics & Sports Medicine

1. **No more than 2 residents gone from an institution at a time or on a Friday, unless approved for special circumstances.**
2. **One week per quarter unless approved for special circumstances**
3. **Two months notice on all vacation requests**
4. **Once approved you will receive a copy in your mailbox as well as an email**

Last Name:_____ First Name: **_____**

First Day _____ Last Day _____ No. of Work Days Requested _____

Type of Absence: Vacation ___ Sick ___

Test _____ Conference _____ Name of Conference _____

Number of Residents off _____

ROTATION:_____ Hospital: _____

RESIDENT SIGNATURE:_____ **DATE: _____**

ROTATION SERVICE CHIEF SIGNATURE: _____
(Please obtain signature before handing in request)

DATE: _____

Dr. G. Douglas Letson:_____Date:_____
Ann Joyce:_____Date:_____