NOTE: All Leave Is Required To Be Requested 30 Days In Advance

Department of Surgery Faculty Leave Request Form

Name and Division: ____________________________  Today’s Date: ________

First day gone from work: ____________  First day returning to work: ____________

Type of Leave Requested:

Annual (# of hours) ________  Professional (# of hours) ________

Sick (# of hours) ________

If Professional Leave, list reason including destination and payment source:

Reason: ________________________________________________________________

Destination: __________________________________________________________

Payment Source: _______________________________________________________

Additional Information: ________________________________________________

Coverage:

List coverage arranged for Leave: _______________________________________

Operating and Clinic Cancellation(s):

OR/OSIS TIMES MUST BE RELEASED AND CLINICS CANCELLED IF NOT NEEDED

List any dates OR and/or OSIS are to be cancelled: __________________________

List any dates clinic is to be cancelled: __________________________

Requesting Faculty Signature: ___________________________________________

Division To Complete:

Division Notified: ☐  Calendar Checked for Conflicts: ☐

UH Clinic Notified: ☐  Call Covered: (if applicable): ☐

UH Clinic Cancelled: ☐  Outreach Clinic Cancelled: ☐

Approvals:

Division Chief: _______________________________________________________

Department Chair: _________________________________________________

Updated 4/8/2011-LjA