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