Department of Surgery Staff Leave Request Form

NOTE: All Leave Should Be Requested With As Much Advance Notice As Is Possible

Employee Name & Division: ______________________________ **Today's Date:** __________

First day gone from work: ____________________ First day returning to work: ________________

Type of Leave Requested:

Annual (# of hrs. and times out if less than 8 hrs.): ______________ Sick (# of hrs. and times out if less than 8 hrs.): ____________

Prof. (# of hrs. and times out if less than 8 hrs.): ________________

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

Reason: ____

Destination: ____

Payment Source: ____

Additional Information: ____

Other Leave (# of hrs. and times out if less than 8 hrs.; state type of leave): ______________________

Coverage:

Coverage arrangements are required for leave taken in advance. Leave will be approved or denied based on coverage arrangements. Anyone listed as providing coverage is required to sign/date as acknowledgment and agreement:

List pre-arranged coverage (include name(s) and division(s) providing coverage):

*Printed Name/Division: ____

Signature: ______________________________ Date: ________________

*Printed Name/Division: ____

Signature: ______________________________ Date: ________________

Clinic Notified: ☐ Yes ☐ N/A

Provide name, phone and email of clinic coverage: ______________________________

Anyone who has agreed to provide coverage is responsible for finding an alternate if they cannot follow through with the commitment.

Required Approvals (Division Supervisor/Div. Chief Approval/Denial Can Not Be The Same Person Providing Backup Coverage):

Supervisor/Div. Chief: ☐ Approved ☐ Denied Signature: ______________________ Date: ________

Administration: ☐ Approved ☐ Denied Signature: ______________________ Date: ________

Comments: ____

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Administrative Use Only:

Calendared by: ______________ *Date:* ________ *Requester Notified of Approval/Denial by:* ______________ *Date:* ________
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