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: _______________________________________________________________________________________

Administrative Use Only:
Calendared by: __________ Date: ______ Requester Notified of Approval/Denial by: __________ Date: ______

Updated 10/28/2013-LjA