FACULTY REQUEST FOR LEAVE

Name: ______________________________________ Date of Request:______________________

Type of Leave: ____Annual Leave ____Sick Leave ____Off Campus ____Other (Specify)

From (date): ________________________________ To (date): __________________________________

Remarks:
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____ ____________________________
Faculty Signature Requesting Leave Date

Approved: _________________ Not Approved:
____

____ ____________________________
Signature of Division Chief Date

cc: Requesting Employee
Department of Medicine
Section Personnel File