



School of Medicine
Department of Psychiatry and Health Behavior

RESIDENT LEAVE REQUEST FORM

The resident taking leave must provide a copy of this completed form to the Residency Training office
45 days prior to taking leave.

I, _____ hereby request: (check one)
(print name)

_____ **Annual Leave**

_____ **Educational Leave**
Purpose: _____

_____ **Medical Leave**
Specify Medical Reason: _____

First Work Day Absent: ____/____/____ Last Work Day Absent: ____/____/____

Return to Work Date: ____/____/____ Total Number of Work Days Absent: _____

Telephone Number(s) to be Reached in Case of Emergency: _____

(Resident Requesting Leave Signature)

(Date)

For leave to be authorized, the resident requesting leave must obtain all signatures requested below .

Supervisor/Attending Approval, Date

Covering Physician Signature, Date

Chief Resident Approval (re: call coverage), Date

(Vikki Sowell for VA approval if applicable)

Residency Training Coordinator , Date

Training Director Signature, Date