RADIOLOGY LEAVE REQUEST FORM

NAME: _____ **TODAY'S DATE:** _____

Rotation Name: _____

Leave Type (check one)	**Date(s)**
___ Vacation (1 rotation per request)	_____
___ Academic (attach program information and presentation, if applicable)	_____
___ Sick/Medical leave	_____
___ Maternity/Paternity	_____
___ Holiday (Specify religious or work in lieu of holiday)	_____
___ Court (Jury Duty, Subpoena)	_____
___ Bereavement Leave	_____
___ Other	_____

COMMENTS:

APPROVAL:

Program Director: _____ Date: _____

Program Coordinator: _____ Date: _____

Chief Resident: _____ Date: _____

Revised July 11, 2017