RESIDENT LEAVE REQUEST FORM
Dept. of Orthopaedics & Sports Medicine

1. No more than 2 residents gone from an institution at a time or on a Friday, unless approved for special circumstances.
2. One week per quarter unless approved for special circumstances
3. Two months notice on all vacation requests
4. Once approved you will receive a copy in your mailbox as well as an email

Last Name:____________________________ First Name:________________________

First Day _______________ Last Day _______________ No. of Work Days Requested ______

Type of Absence: Vacation ___ Sick ___
Test ____ Conference ____ Name of Conference _________________________________________

Number of Residents off ______

ROTATION:______________________________ Hospital: ______________________

RESIDENT SIGNATURE:__________________________ DATE: _______________

ROTATION SERVICE CHIEF SIGNATURE: _________________________________
(Please obtain signature before handing in request)

DATE: ______________

Dr. G. Douglas Letson: ___________________________ Date: _______________

Ann Joyce: ___________________________ Date: _______________