RESIDENT REQUEST FOR LEAVE

Department of Ophthalmology
Medical College of Virginia
Virginia Commonwealth University

NAME: ______________________________ **PG Year** ________ **DATE:** __________

ROTATION: __________

TYPE OF LEAVE (Circle)

Vacation **Sick** **Meeting** **Basic Science Course** **Interview**

Name of Meeting: ____________________ **Interview Location:**

Meeting Location: ____________________ __________________

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Dates of Leave _________________

Date of Return _________________

Total # of Days ________

****

Where are you scheduled to be:

Monday	Tuesday	Wednesday	Thursday	Friday

_____________________________ __________________

Resident Signature **Date**

Coordinator Approval: ____________________________________

VAMC Approval: ____________________________________

Program Director Approval (if necessary): ________________________________

____ **Approved** ___ **Entered in NI** **Entered Date:** _____________

____ **Denied** ___ **Added to Calendar**