

INTERNS

REQUEST FOR TIME OFF FROM WORK

I, _____, AM REQUESTING

TIME OFF FROM WORK FOR _____.

MY LEAVE DATE IS _____ AT _____ AM PM

MY RETURN DATE IS _____ AT _____ AM PM.

PLEASE BE CERTAIN DATES & TIMES ARE FILLED IN OR WE CANNOT HONOR THIS REQUEST.

REQUESTS MUST BE RECEIVED WITH APPROVAL SIGNATURES AT LEAST TWO (2) WEEKS IN ADVANCE OF YOUR REQUESTED TIME OFF OR APPROVAL CANNOT BE GIVEN.

DATE OF REQUEST _____

INTERN'S SIGNATURE _____

DATE _____

APPROVAL:

ROTATION ATTENDING

DATE APPROVED

CLINIC DIRECTOR

DATE APPROVED

DIRECTOR OF MEDICAL EDUCATION

DATE APPROVED