Internal Medicine Residents
Request for Leave/Clinic Cancellation Form

CLINIC CANCELLATION NOTIFICATION MUST BE RECEIVED 8 WEEKS IN ADVANCE OF THE SCHEDULED ABSENCE.

Resident's Name:_____

Today's Date: _____

Requested Date(s) of Absence: _____

Rotation at Time of Absence: _____

Continuity Clinic Date(s) to be Cancelled: _____

Reason for Request/Cancellation: _____Vacation _____Exams _____ Illness

_____ Conference (circle one: Attending or Presenting)

_____Maternity/Paternity Leave (*Leave of Absence form required)

_____Other (please explain below)

_____

_____

APPROVED BY:

Meredith Stafford
Education Program Coordinator _____
Signature Date

Chief Resident _____
Signature Date

E. Benjamin Clyburn, MD
Program Director _____
Signature Date

DENIED BY:

Denied by: _____ Date of Denial: _____

Reason for Denial: _____

OFFICE USE ONLY:

AMION: _____ **Resident Emailed:** _____
EXCEL: _____ **Jac/Schedulers Notified:** _____