

University of Arkansas for Medical Sciences
DEPARTMENT OF PSYCHIATRY AND BEHAVIORAL SCIENCES

Request for Vacation and Education Leave

Resident: _____ Date: _____
(Print Name)

I request _____ days. Leave Date(s): _____

<u>Type of Leave</u>	<u>Total days taken Before this request</u>	
_____ Vacation	_____	
_____ Educational leave	_____	_____

Name of Conference, Exam, etc.

Rotation Responsibilities:

_____ has agreed to cover my rotation assignment and my supervisor has this information.

Call Schedule Responsibilities:

_____ I am not on call.

_____ will be on call in my place and I have notified the Chief Resident.

Outpatient Responsibilities (PGY 2, 3, 4):

_____ I have notified the clinic secretary.

_____ I have informed my patients as appropriate.

_____ has agreed to cover my out-patient needs (Psychotherapy patient calls, clinic patient calls, etc).

Approval of request:

_____ Date: _____
(Supervisor's(s') Signature(s))

(Supervisor's(s') Name(s) PRINTED)

Adult Outpatient Clinic Signature (PGY 3, 4)

Return completed form to Janis Cockmon

Rev. 12/2013

Signature of Residency Program Director or Designee