WICHITA CENTER FOR GRADUATE MEDICAL EDUCATION

RESIDENTS LEAVE REQUEST

Name _____ Residency Program _____

Total Weekdays (M-F) Absent _____

Dates of Absence: (include weekends)

From _____ Through _____

Reason: Vacation ☐ Education Leave ☐

Sick Leave ☐ *Leave Without Pay ☐

Comments: For vacations and sick leave, please indicate how many days you have remaining after using these days. For education leave, please indicate conference name, place and dates.

_____

_____

Rotation _____ Hospital (Campus) _____

Coverage provided by: _____

Resident's signature: _____ Date: _____

Supervising Physician's signature: _____ Date: _____

Program Director's signature: _____ Date: _____

White copy: Residency Office
Yellow copy: Residency Secretary at the affected hospital
Pink copy: Resident
***Copy to WCGME only if leave without pay** **Rev: 8/98**