

**DEPARTMENT OF PATHOLOGY
FACULTY LEAVE FORM
(2 weeks prior notice required)**

Name: _____

Number of work days requested: _____

Inclusive dates: _____ Through: _____

Type of leave requested:

Vacation

Professional leave Meeting/conference: _____

Location: _____

Government leave Reason: _____

Location: _____

Sick leave Self Family

Date: _____ Signature: _____

Inclusive dates coverage will be required:

Clinical duties will be covered by:

Dr.(s) _____

Teaching duties will be covered by:

Dr.(s) _____

These duties include:

A) _____

B) _____

C) _____

These duties include:

A) _____

B) _____

C) _____

Approved: _____
Lab director/scheduler

Course Director

Approved: _____
Clinical chief/Chairman