Department of Radiology
Resident Time off Request

Name: ______________________________ Today's Date: ______________________

Rotation and location of rotation (MCG/VA - **circle**) during time off: ______________________

Dates of leave requested: ____

Type of Leave (**circle**)

Vacation Meeting (OC) – Specify ________________ Other: ________________

Phone Number where you can be reached (cell): ______________________________________

Total number of days requested: ____________

Number of vacation days used this fiscal year (ask PC for this information): ____________

There is/is not a conflict (**circle**)

Approval:

Chief Resident	____ Yes	____ No	________ Date	________ Initials
Section Chief MCG/VA (**circle**)	____ Yes	____ No	________ Date	________ Initials
Program Director:	____ Yes	____ No	________ Date	________ Initials

In case of disapproval, complete the following:

Reason for disapproval:

Chief Resident: ________________

Section Chief: ________________

Program Director: ________________

____
Resident's Signature

____
Date