University of Oklahoma Health Sciences Center
College of Medicine
DONALD W. REYNOLDS
DEPARTMENT OF GERIATRIC MEDICINE

OUHSC & VA CLINICAL FACULTY
REQUEST FOR LEAVE FORM

(Must be submitted four (4) weeks in advance of scheduled leave)

NAME: _____ DATE OF REQUEST: _____

LEAVE TYPE:	FROM:	TO:
PROFESSIONAL LEAVE (**If requesting professional leave, you **must** attach a copy of the meeting brochure or flyer, etc)* Meeting Name:_____ Location:_____	_____ (AM/PM)	_____ (AM/PM)
PERSONAL LEAVE (*please mark appropriate personal leave type*) ☐ Paid Leave ☐ Leave Without Pay ☐ Short-Term Disability ☐ FMLA ☐ **ML ☐ **Jury Duty ☐ Other_____ *. **If you are requesting ML or Jury Duty, you **must** attach a copy of military orders.*	_____ (AM/PM)	_____ (AM/PM)

COVERAGE

NAME/TITLE OF COVERING ASSOCIATE
*The covering associate(s) MUST **sign** their name accordingly.*

CLC/PCU _____

SHC _____

Other _____

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PATIENT CALLS / EMERGENCIES

DAYTIME _____

NIGHTS / WEEKENDS (On-Call) _____

CLINIC CHANGES/ COMMENTS (Note: Block refers to hours within workday, Closed refers to entire day)

_____

_____

Please note: Clinics are not to be canceled within 30 days of the patient appointment(s). The only exceptions will be for physician illness, emergency, or death within a family. All requests to cancel/reschedule clinics must be approved by the Chairman. If the requested date for cancellation/reschedule is less than 5 days, the physician must make arrangements to have the scheduled patients, who have not been notified of the cancellation, seen by another provider. Faculty members who must cancel/reschedule a clinic need the Chairman's approval. Clinic staff will not implement the change request without the approved request for leave form.

Leave has been requested into DHCP/Vista (KEA) _____
Requestor's Initial

APPROVED / DISAPPROVED: _____ _____
Professor & Chair, DWR Department of Geriatrics Date