THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

LEAVE REQUEST

NAME: _____ EMP# _____ DATE _____

EXPLANATION _____

(Attach doctor's certification for absence of 32 hours or more due to illness)

NUMBER OF HOURS	TYPE OF LEAVE	FROM		THRU	
		DATE	TIME	DATE	TIME
	Personal				
	Major Medical				
	Holiday				
	Training / Administrative				
	Uncompensated Absence				
	Total Hours Requested	**By:**			

Employee Signature

Clinics / Dates to be Rescheduled: _____

Approved: _____ Denied _____

APPROVAL:

Comments: _____

_____

Supervisor

_____

_____

Department Head

_____

Chief Administrative Resident

Faculty/Nurses on Service =

_____

Chief Resident on Service

Send COMPLETED / SIGNED forms to **Tara Kelly**

Orthopedic Surgery and Rehabilitation
2500 North State Street * Jackson, Mississippi 39216
T 601.984.6525 * umhc.com
Clinical Programs of The University of Mississippi Medical Center