MEDICINE RESIDENCY
Request to Change a Rotation or Vacation
or
Request Conference, Interview, or Personal Leave

Name: ______________________ **Today's Date:** ______________________

If you need to make a change to your schedule or request time off for personal or professional reasons, please complete this form. The Residency Office must approve all schedule changes or requests for time off. Please make your request as early as possible, preferably 2 months prior to the date of your change.

After you have completed this form and obtained the necessary approvals, please send to the Medicine Residency Office (Box 356421 or Fax 685-8652). We will make every effort to accommodate your request and to process your form within three days of receipt. If you have any questions, please feel free to contact the Residency Office (543-3605).

I would like to: ☐ Change my vacation ☐ Change a rotation

I am currently scheduled | I would like to change to

Dates: ______________________ Dates: ______________________

Rotation: ______________________ Rotation: ______________________

Name of other resident involved in this change (if applicable): ______________________

Is currently scheduled | Would like to change to

Dates: ______________________ Dates: ______________________

Rotation: ______________________ Rotation: ______________________

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Signature of other resident date

I would like time off to: ☐ Attend a conference ☐ Interview for a fellowship ☐ Other ______________

Dates: ______________________ Rotation: ______________________

Conference Title: ______________________ Conference location: ______________________

Comments:

Other Responsibilities during requested time:

At Risk? ☐ Yes ☐ No Weekend Call? ☐ Yes ☐ No

Approval: *Final approval is at the Residency Program Director's discretion*. Obtain the following signatures or verbal/electronic approvals (note the name of the person you contacted and the date you obtained approval).

Attending or Section Chief (*inpatient or consult rotations)* **or**
Rotation Director *(ambulatory rotations)* ______________________ date

Continuity Clinic Director **or** Coordinator *(all rotations)* ______________________ date

Chief Resident *(inpatient or consult rotations only)* ______________________ date

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Residency Office Use: ☐ **Approved (**☐ **with pay** ☐ **without pay)** ☐ **Disapproved**

______________________ **Date notification sent**: ______________________
Signature date

Revised 8/17/04