

LSUHSC Department of Neurosurgery Request for Vacation/Leave

Resident Name: _____

Date Requested: _____

Nature of Leave

- Vacation
- Leave of Absence
- Maternity/Paternity
- Educational; comments _____
- Sick
- Other; comments _____

Beginning Date of Leave: ___ / ___ / ___

Date of Return: ___ / ___ / ___

Number of total work days missed : _____

Resident Signature: _____

Chief Resident Signature: _____

Staff supervising current rotation signature: _____

Program Director Signature: _____