

RESIDENT SICK LEAVE BANK REQUEST

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BANNER E#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Street)(City/State) (Zip Code)

PROGRAM/SPECIALTY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PGY:\_\_\_\_\_\_\_\_\_\_\_\_\_

REQUEST

DATE ACCUMULATED ANNUAL AND SICK LEAVE EXPIRED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NUMBER OF DAYS REQUESTED FROM THE RESIDENT SICK LEAVE BANK:\_\_\_\_\_\_\_\_

ATTACHED IS MY PHYSICIANS STATEMENT VERIFYING THE NATURE OF THE ILLNESS OR INJURY AND MY INABILITY TO WORK.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE Signature of Resident

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE Program Director

APPROVAL

(To be completed by Trustees)

REQUEST APPROVED: YES:\_\_\_\_\_ NO:\_\_\_\_\_ NUMBER OF DAYS APPROVED:\_\_\_\_\_\_

EFFECTIVE DATES: FROM:\_\_\_\_\_\_\_\_\_\_ TO:\_\_\_\_\_\_\_\_\_\_\_\_

COMMENTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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DATE RESIDENT SICK LEAVE BANK CHAIRPERSON