LOYOLA UNIVERSITY DEPARTMENT OF NEUROLOGY

REQUEST FORM FOR STUDENT LEAVE OF ABSENCE

DATE OF REQUEST: ____

NAME: ____
(PLEASE PRINT)

E-MAIL ADDRESS: _______________ **PAGER#** _____________**HOME PHONE**__________

FIRST DAY OF ABSENCE _____________ **DATE OF RETURN** ____________________
NO MORE THAN THREE DAYS WILL BE ALLOWED

TOTAL NUMBER OF DAYS ABSENT ________________________________

SERVICE AT TIME OF ABSENCE _________________________________

<u>All appropriate signatures must be obtained for leave to be approved</u>:

_______ Clinic Attending's approval __________________________ ______________________
(date) **(name)** **(signature)**

_______ Service Resident Notified __________________________ ______________________
(date) **(name)** **(signature)**

_______ Service Attending's approval __________________________ ______________________
(date) **(name)** **(signature)**

______________________________________ ______________________
STUDENT'S SIGNATURE **DATE**

______________________________________ ______________________
SITE COORDINATOR'S SIGNATURE **DATE**

FORM MUST BE COMPLETED, SIGNED AND RETURNED <u>BEFORE</u> THE LEAVE OF ABSENCE BEGINS TO: JACKIE GREER, ROOM 320, SSOM, 708-216-8083; FOR HINES, Bldg 228, Room 5000 (Psych Bldg.) 708-202-2843

(Please request that Hines fax completed form to Jackie).

Fax: 708-216-5318

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