

## CLINICAL YEAR STUDENT TIME OFF REQUEST FORM

THIS FORM IS DUE NO LESS THAN 30 DAYS PRIOR TO THE FIRST DAY REQUESTED OFF.

Student Name: \_\_\_\_\_

**Date(s) requested off**

**Reason for time off request**

☐ Religious Observance

☐ Holiday

☐ Other

**Explanation of why the absence is necessary**

***Submission of this form does not constitute approval. Students should not assume a request has been granted until a notification has been sent that this request is approved. Only complete forms will be considered.***

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

☐ **Approved**

☐ Make up time REQUIRED

☐ Make up time at preceptor discretion

☐ Denied

Reason for denial

Director of Clinical Education Signature: \_\_\_\_\_ Date \_\_\_\_\_

Date student notified \_\_\_\_\_