East Tennessee State University
James H. Quillen College of Medicine
Department of Psychiatry and Behavioral Sciences
Box 70567, Johnson City, TN 37614-1707
(423) 439-8010 Fax (423) 439-2210

REQUEST for ANNUAL or SICK LEAVE

TO: **C. Allen Musil, Jr., MD**
Chair

FROM: _____

DATE: _____

As indicated below, I am requesting ☐ **ANNUAL LEAVE** ☐ **SICK LEAVE**
☐ **OTHER** _____

_____ through _____
(Date and Time) (Date and Time)

_____ Date and time I will return to work.

_____ has agreed to provide **University Call Coverage**

_____ Covering physician SIGNATURE

_____ Covering physician SIGNATURE – "Fill & Sign"

_____ has agreed to provide **Resident Clinic Responsibilities**

_____ Covering physician SIGNATURE

_____ Covering physician SIGNATURE – "Fill & Sign"

_____ Emergency phone number.

_____ Actual hours of leave

Additional Comments or Coverage

_____
Faculty Name Printed

_____
Faculty Signature and Date

_____
Faculty Signature and Date (if using "Fill and Sign")

Revised 1/28/21