



ORTHOPAEDICS REQUIRED CLERKSHIP EXCUSED ABSENCE REQUEST FORM

Please complete all sections and inform the attending you are will be working with of your planned absence. This form must be turned into the Clerkship Coordinator.

Name: _____ Class Year: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Mobile: () _____ Pager: () _____

Request from:

Day: Monday Tuesday Wednesday Thursday Friday Saturday Sunday
Date: _____ Time: _____
 ALL DAY, one day

Returning:

Day: Monday Tuesday Wednesday Thursday Friday Saturday Sunday
Date: _____ Time: _____

Clinical Site: _____

Scheduled activities that will be / have been missed:

Reason for absence: _____ Verification (doctor's note, boarding pass, etc.) attached: Yes No

I understand that I am responsible for all clerkship/curriculum content during my absence, and it is MY responsibility to contact the clerkship coordinator no later than the first day of my return to complete outstanding requirements.

Student Signature

Date

Approve Disapprove – Reason: _____

Approval Signature

Date