

**Mercer University School of Medicine  
Department Leave Request/Approval Form for Faculty**

**Leave Request must be submitted to Department Chair 10 working days in advance.**

**(If Faculty Member practices for Mercer Medicine, please obtain covering physician signatures and notify Mercer Medicine prior to submission to Department Chair. Leave is not approved until signed by Department Chair.)**

Faculty Name: \_\_\_\_\_

**Request for Leave (Please indicate type):**

Vacation      Date(s): \_\_\_\_\_

Sick      Date(s): \_\_\_\_\_

Please indicate type of sick leave below:

\_\_\_\_ Faculty Sick Leave – (If more than 3 consecutive days, must contact Human Resources.)

\_\_\_\_ Workers' Comp Leave

\_\_\_\_ Family Medical Leave – (Must be approved by Human Resources.)

Unpaid Leave      Date(s): \_\_\_\_\_

Purpose of unpaid leave: \_\_\_\_\_

(Must be approved by Chairman, Dean of MUSM, and HR.)

Conference      Date(s): \_\_\_\_\_

(Includes seminars, workshops, off-site training courses, educational conferences, etc.)

**NOTE: Separate pre-authorization required for conference reimbursement.**

Jury Duty      Date(s): \_\_\_\_\_

Military Leave      Date(s): \_\_\_\_\_ (Must provide copy of orders to HR.)

Presentation/Talk      Date(s): \_\_\_\_\_

Time out of office: \_\_\_\_\_

Other Leave:      Date(s): \_\_\_\_\_

Please describe: \_\_\_\_\_

\_\_\_\_\_

Physician(s) providing Coverage (clinical faculty) – *have covering physician initial & date:*

Name: \_\_\_\_\_ Acknowledgement: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_ Acknowledgement: \_\_\_\_\_ Date: \_\_\_\_\_

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Mercer Medicine Notified: \_\_\_\_\_ Date: \_\_\_\_\_

Sufficient leave available: \_\_\_\_\_ Logged to master calendar: \_\_\_\_\_

Department Chair's Approval: \_\_\_\_\_ Date: \_\_\_\_\_

MUSM Dean's Approval (if necessary): \_\_\_\_\_ Date: \_\_\_\_\_

HR Approval (if necessary): \_\_\_\_\_ Date: \_\_\_\_\_