

**UF Department of Psychiatry
Faculty Leave & Coverage Request**

Today's Date: _____

Date/Time of Absence: _____

Employee's UFID: _____

Start Date: _____ Start Time: _____

Employee's Name: _____

End Date: _____ End Time: _____

Total Hours Absent: _____ (Please round to quarter increments: .25, .50, .75 as appropriate)

Type of Leave:

- Vacation
- Sick
- Conference or Study Section:

December Personal Leave Days:

- Used December 27-30 (non-essential personnel)
- Used December 1 – June 30 (essential personnel only)

Hours This Event: _____ Remaining Hours: _____

Other: _____

Type of FMLA Event (If Applicable):

- FMLA Vacation
- FMLA Sick
- FLMA Leave without Pay
- Paid Parental Leave
- Paid Family Leave
- Military, long term

Leave Without Pay*:

- Authorized Unauthorized

*I am requesting leave without pay for the following reason(s):

Faculty Clinical Coverage:

Administrative: _____ Initial

Patient: _____ Initial

Chief of Service _____ Initial

Clinic* _____ Initial

Note Clinical Cancellation must be approved & requires 45 days prior notice

Employee Signature: _____ Date: _____

Approved: _____ Date: _____
Supervisor