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:

_____

☐ Other: _____

December Personal Leave Days:

☐ Used December 26-29 (non-essential personnel)

☐ Used December 2 – June 30 (essential personnel only)

Hours This Event: _____ Remaining Hours: _____

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

Updated 7/1.2022