FACULTY PRIOR APPROVAL LEAVE REQUEST FORM

Department of Family and Community Medicine

Name: **Date**:

ANNUAL LEAVE *(accrued at 14 hours per month @ 1.0 FTE)*

Dates of Leave: _____ Total Hours Requested: _____

INTERNAL/DEPARTMENTAL SICK LEAVE *(10 days per fiscal year, July – June, @1.0 FTE)*

Dates of Leave: _____ Total Hours Requested: _____

PROFESSIONAL LEAVE *(12 days per fiscal year, July – June, @1.0 FTE)*

Dates of Leave: _____ Total Hours Requested: _____

Purpose of Professional Leave: _____

_____

_____ _____

Requestor Signature or attach Electronic Documentation *Date*

_____ _____

Medical Director/Program Director Signature *Date*

_____ _____

Chair's Signature (Required for All Leave) *Date*

Note – All paid leave requires advance prior approval by the Chair. Please send completed/approved form, questions or leave balance requests to FCM HR (Rm 355 FMC, MSC 09 5040 or at FCM-HR@salud.unm.edu).