Dermatology Residency
Western University of Health Sciences

Elective / Vacation Request Form

Resident Name : _____ R1 / R2 / R3

Dates Requested : _____ Elective / Vacation

Total # of days : _____

- **Elective**
  - **Location / Attending :**
  - **Contact (email / phone) :**

Resident Signature : _____ Date : _____

_____ Chief resident initials - required to confirm no scheduling conflicts or overlap with other resident vacations or conferences.

APPROVED / DENIED

Program Director Signature : _____ Date : _____

NO ELECTIVES / VACATION THE LAST 3 WEEKS OF THE ACADEMIC YEAR

THIS FORM MUST BE APPROVED 2 MONTH PRIOR TO ELECTIVE / VACATION