UNIVERSITY OF ROCHESTER
SCHOOL OF MEDICINE AND DENTISTRY
ADVANCED CERTIFICATE PROGRAM
CLINICAL/MEDICAL LABORATORY TECHNOLOGY

GRADUTATE STUDENT VACATION REQUEST FORM

GRADUATE STUDENT: ______________________________

DATE/S REQUESTED: ______________________________

DATE REQUEST SUBMITTED*: ______________________________

LIST THE CLINICAL ASSIGNMENTS AND LECTURES IMPACTED BELOW:

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PLEASE CIRCLE THE APPROPRIATE RESPONSE TO THE STATEMENTS BELOW

YES OR NO: I have discussed my request with the instructors of the areas of impact listed above.

YES OR NO: If the answer to the above statement is "YES" a plan has been approved to make up missed work. The plan is as follows: ____

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THE FINAL DETERMINATION FOR THIS REQUEST IS:

APPROVED_________________ NOT APPROVED_______________

COMMENTS: ____

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PROGRAM DIRECTOR SIGNATURE ______________________________

DATE RETURNED TO GRADUATE STUDENT ______________________________

(*The policy requires a minimum of 2 weeds prior to the dates requested.)