

RESIDENT VACATION / CONFERENCE REQUEST
DEPARTMENT OF ORTHOPAEDICS

DATE _____

NAME _____

A. VACATION

Dates Requested (inclusive) _____

B. Conference

Title of Conference _____

Sponsoring Organization _____ # CME credits _____

Dates and Location of Meeting _____

Dates Requested (inclusive) _____

Request for Travel Funding (NO MONEY WILL BE PAID WITHOUT RECEIPTS)*

Registration _____ Hotel _____

Transportation _____ Meals _____

Other (specify) _____ Other (specify) _____

TOTAL _____

RESIDENT'S SIGNATURE _____ DATE _____

CHIEF RESIDENT APPROVAL ** _____ DATE _____

CHIEF OF SERVICE APPROVAL ** _____ DATE _____

* IRS and University policy requires copies of receipts within 1 week after returning to Buffalo

** Service at the time of requested leave

OFFICE USE ONLY

Approved for Vacation _____

Conference _____

Check # _____

Amount _____

If Denied _____

Date _____

Reason _____

Receipts Received _____
