UVU PHYSICIAN ASSISTANT PROGRAM
UTAH VALLEY UNIVERSITY

CLINICAL YEAR STUDENT TIME OFF REQUEST FORM

THIS FORM IS DUE NO LESS THAN 30 DAYS PRIOR TO THE FIRST DAY REQUESTED OFF.

Student Name: _____

Date(s) requested off

Reason for time off request

☐ Religious Observance ☐ Holiday ☐ Other

Explanation of why the absence is necessary

Submission of this form does not constitute approval. Students should not assume a request has been granted until a notification has been sent that this request is approved. Only complete forms will be considered.

Student Signature _____Date_____

☐ **Approved**

☐ Make up time REQUIRED ☐ Make up time at preceptor discretion

☐ Denied

Reason for denial

Director of Clinical Education Signature: _____ Date_____

Date student notified_____