UMDNJ
NEW JERSEY MEDICAL SCHOOL
University of Medicine & Dentistry of New Jersey

DIVISION OF CHILD AND ADOLESCENT PSYCHIATRY
DEPARTMENT OF PSYCHIATRY
BHSB, ROOM F-1542
183 S. ORANGE AVE
NEWARK, NJ 07101

# HOUSESTAFF VACATION REQUEST FORM

**Trainee's Name:** ______________________

**Date of Request:** ______________________

**Beginning Date:** ______________________

**Ending Date:** ______________________

**Total # of Days:** ______________________

1. Clear proposed dates with Training Director. Initials: __________ Date: ____________
2. Obtain signatures for coverage from trainees and (clinical or administrative) supervisors of services where you are assigned.

| *Service* | *Trainee (date)* | | *Supervisor (date)* | |
|---|---|---|---|---|
| UBHC Outpatient | | | | |
| Challenge Program | | | | |
| Continuity Clinic | | | | |
| Inpatient Service | | | | |
| ER-C/L Duties | | | | |
| The Autism Center | | | | |
| Tourette Clinic | | | | |
| Elective | | | | |

3. Obtain Training Director signature.

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Training Director