

ABSENCE FORM FOR VISITING MEDICAL STUDENTS

STUDENT NAME: _____

ROTATION: _____

DATES OF ROTATION: _____

ABSENCE DATES REQUESTED: _____

PURPOSE OF ABSENCE: _____

FACULTY SPONSOR: _____

APPROVAL SIGNATURE

DATE: _____

PLEASE RETURN FORM TO:

Andrea Beyer
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BEYERA@CCF.ORG
FAX: 216-636-1348