



Clerkship Program Excused Absence Request

Please allow 3-5 business days for processing

Students: Please review your course syllabi and the Clerkship Attendance Policy prior to requesting an absence from clerkship. It is the responsibility of the student to follow the absence requirements of the course and failure to follow course requirements may result in an N grade.

Student Information: Please PRINT

Student name: _____ Phone: (____) _____ - _____
 Email: _____ Class Year: _____
 Site/Base Hospital: _____ Date (s) for Absence: _____
 Name of Rotation _____ Location: _____

Reason for absence request (requires additional documents per policy**):

- Absence for interviews** (cannot exceed 4 total days on any one rotation unless approval from MSUCOM Instructor of Record)
- Absence for examinations (see policy)
- Absence for conference** (see policy)
- Absence for personal day (cannot exceed 2 on any one rotation or 5 per academic year)

Comments: _____

Supervising Attending of the rotation for which the absence is requested: Please PRINT

The MSUCOM student is requesting an absence from your rotation for the above dates and reason. Please complete the below to assist us in the absence request. The student will supply a final copy of this document to you on the first day of the rotation if the absence is approved by the Medical Education Department.

- Would support absence from rotation, if approved by the Medical Education Department
 Terms for making up the absence: _____
- Would not support absence from rotation
 Reason: _____

Supervising Attending Physician Signature: _____ Date _____
 Printed Name: _____

Medical Education Department Approval: Please PRINT

- Request Approved
 Official Medical Education Signatory: _____ Date _____
 Printed Name: _____
- Request Denied
 - Needs supporting Documentation: _____
 - Needs MSUCOM Departmental (Instructor of Record) approval (send to osteomedreg@hc.msu.edu for routing)

MSUCOM Instructor of Record (Departmental) Approval: Please PRINT

- Request Approved
 Instructor of Record Signature: _____ Date _____
 Printed Name: _____
- Request denied
 Comments: _____

A copy of the form will should be sent to the following parties: Please PRINT

<input type="checkbox"/> DME Office Signatory	Name: _____	Email: _____
<input type="checkbox"/> Supervising Attending	Name: _____	Email: _____
<input type="checkbox"/> MSUCOM Student	Name: _____	Email: _____