



**DALHOUSIE  
UNIVERSITY**

**Postgraduate  
Medical Education**

**RESIDENT VACATION/CONFERENCE**  
**REQUEST FORM**

Resident: \_\_\_\_\_

Program: \_\_\_\_\_

Service assigned to: \_\_\_\_\_

Location: \_\_\_\_\_

Duration of request: FROM \_\_\_\_\_ TO \_\_\_\_\_

Date request submitted: \_\_\_\_\_ Date Approved: \_\_\_\_\_

Signature Service (See attached list): \_\_\_\_\_

Date submitted to Home Program: \_\_\_\_\_ Date Approved: \_\_\_\_\_

Signature Home Program Director: \_\_\_\_\_

*Copies should be retained by all those who sign for record keeping purposes.*