



**REQUEST FOR EDUCATIONAL LEAVE TIME**

NAME: \_\_\_\_\_

DATE AND/OR TIME REQUESTED: \_\_\_\_\_

AMOUNT OF EL TIME AVAILABLE: \_\_\_\_\_

COURSE TITLE: \_\_\_\_\_

COURSE CONTENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

YOUR OBJECTIVES IN ATTENDING:  
(Attach Course Description, if Available)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Number of CEUs Provided: \_\_\_\_\_

If Home Study, How Many Hours Did It Take to Complete? \_\_\_\_\_

\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
CLINICAL MANAGER SIGNATURE/AUTHORIZATION