

**PEDIATRIC DENTISTRY  
PREDOCTORAL  
REQUEST FOR PLANNED ABSENCE**

STUDENT NAME: \_\_\_\_\_ CLASS \_\_\_\_\_ DATE: \_\_\_\_\_

REQUESTED DATE OF ABSENCE: \_\_\_\_\_

REASON: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PERMISSION BY: \_\_\_\_\_ (can only be approved by Drs. listed below)  
(DAVIS, METCALF, KOHLI, PADILLA)

DATE GIVEN TO APPOINTMENT SECRETARY: \_\_\_\_\_

Do you have a regularly assigned patient for this date? \_\_\_\_\_ Name: \_\_\_\_\_

**Please submit filled out and signed slip to the appointment secretary no later than 5 clinic days prior to proposed absence.**