

# SCHEDULE CHANGE REQUEST FORM

Changes and cancellations must be requested at least **12 weeks** in advance.

*NOTE: Changes should not be considered implemented until you receive a signed copy of this form.*

Request submitted by \_\_\_\_\_

Date \_\_\_\_\_

Advisor \_\_\_\_\_

## OUTPATIENT CLINIC CHANGES

Clinic/Team	Date/Time of Sessions to Cancel	Date/Time of Make-up Sessions	Date Returning to Normal Schedule
_____	_____	_____	_____
_____	_____	_____	
_____	_____	_____	

**REASON** for Request \_\_\_\_\_

## ROTATION, CALL, AND OTHER CHANGES

Resident	Rotation/Shift	Date	Change to be made (add, cancel, make-up)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**REASON** for Request \_\_\_\_\_

## REVIEW AND APPROVALS

All *clinic changes* must be approved by the FHC Medical Director and reviewed by the Residency Director.  
All *rotation, call, and back-up changes* must be reviewed and approved by the Residency Director and Chief Residents.

Received by Scheduling Coordinator	Date
_____	_____
FHC Medical Director	Date
_____	_____
Residency Director	Date
_____	_____
Chief Resident	Date
_____	_____

**CHANGES HAVE BEEN MADE**

**CHANGES CANNOT BE MADE**

*Please call patients to reschedule their appointments.*

## COMMENTS

\_\_\_\_\_

**Please submit all forms in mail room drop-box only.**

Leaving forms in individual mailboxes causes delays which may make it impossible for us to honor your request.