NEW YORK MEDICAL COLLEGE
A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM
Graduate School of Basic Medical Sciences

PhD Student Parental Leave Request

Ph.D. Student Name _____

Advisor _____

Department_____

Date Request Initiated_____

Parental Leave Dates Requested _____

Total Duration of Leave Requested (weeks/days) _____

Explanation of Qualifying Event _____

_____

Request Approved _☐_ Denied_☐_

Advisor Signature_____Date_____

Program Director Signature_____ Date_____

Department Chair Signature_____ Date_____

GSBMS Dean Signature_____ Date_____

Approver Comments _____

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