



**Holiday Compensation Form**

Date:  
Resident Name:  
Program:  
Holiday Worked (include date):  
Hospital Where Worked:

List three dates (within three months of the holiday) in order of preference for alternate day off:

- 1.
- 2.
- 3.

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Resident Signature

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To be completed by program director/designee:

Check One:

- Alternate Day off granted for:
- Resident elected to defer alternate day off
- Pay granted in lieu of alternate day off

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PD/designee signature

Form must be submitted by the resident no more than ten business days from the holiday worked. Program director shall respond to the request within ten business days. The form must be completed no later than three months after the holiday worked.

-original to be kept in resident file

-copy to be given to resident

-copy to be sent to GME office

**Revised: May 2015**