NOTICE OF LEAVE FORM

☐ PAID MEDICAL/SICK LEAVE
☐ PAID EMERGENCY/FAMILY/BEREAVEMENT LEAVE (Maximum 5 working days)
☐ MATERNITY LEAVE
☐ PARENTAL LEAVE

☐ UNPAID LEAVE – Please identify reason:  
   Educational/Academic/Research  
   Personal/Compassionate

TO:  POSTGRADUATE MEDICAL EDUCATION

FROM: ___________________ DEPT: ___________________ PROGRAM: ___________________

DATE: ___________________ TEL. NO: ___________________

HOSPITAL SITE: ___________________ ROTATION: ___________________

HOSPITAL MEDICAL EDUCATION CONTACT: ___________________

TRAINEE NAME: ___________________ TRAINING LEVEL: ___________________

<table>
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<tr>
<th>LAST DAY OF WORK</th>
<th>OFFICIAL START DATE OF LEAVE</th>
<th>LAST DAY OF LEAVE</th>
<th>OFFICIAL DATE OF RETURN</th>
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NAME: __________________________________ PROGRAM DIRECTOR

SIGNATURE: __________________________________ PROGRAM DIRECTOR

**Please inform the following for any type of leaves at least one month prior: Rotation Supervisor, the Site Coordinator and Hospital Medical Education Office

Revised: FEBRUARY 2017