Postgraduate Medical Education
UNIVERSITY OF TORONTO

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: _____

LAST DAY OF WORK	OFFICIAL START DATE OF LEAVE	LAST DAY OF LEAVE	OFFICIAL DATE OF RETURN

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

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