**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:**  
______________________________

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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