Ouano Avenue, City South Special Economic
Administrative Zone, Mandaue City
Contact # 517 - 0888

MEDICAL STAFF LEAVE OF ABSENCE NOTIFICATION FORM

SFM-CME-007-00

NAME:	DEPARTMENT:	SECTION:	DATE FILED:

INCLUSIVE DATES OF LEAVE		TOTAL NUMBER OF DAYS	EXPECTED DATE OF RETURN TO WORK
FROM:	TO:		

DESTINATION

- ☐ WITHIN CEBU CITY
- ☐ OUT OF CEBU CITY BUT WITHIN PHILIPPINES
- ☐ OUT OF THE PHILIPPINES

REASON FOR LEAVE

- ☐ VACATION LEAVE
- ☐ MATERNITY LEAVE
- ☐ PATERNITY LEAVE
- ☐ CONVENTION CONFERENCE
- ☐ TRAINING (Please specify): ____________________________________
- ☐ OTHERS:________________________
- ☐ EMERGENCY LEAVE (Please specify): ____________________________________
- ☐ SICK LEAVE (Please specify): ____________________________________

DECLARATION:
The Physician(s) to cover during my leave (coverage must be of the same specialty/subspecialty) are as follows:

1.	2.	3.

I have informed my patient(s), if any, of my leave and they are amenable to the physician(s) who will cover for me during my leave. Below is a list of my patients and the corresponding doctors to cover.

NAME OF PATIENTS	DIAGNOSIS	ROOM NUMBER	PHYSICIAN TO COVER
1.			
2.			
3.			
4.			
5.			

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SIGNATURE OVER PRINTED NAME

Noted by:	Recommending approval:
______________________________ Section Head/Department Chairperson (Signature over Printed Name/Date)	______________________________ Chief of Clinics (Signature over Printed Name/Date)
Approved by:	Remarks/Comments
______________________________ Medical Director (Signature over printed name)/(Date)	