

## NOTIFICATION OF LEAVE OF ABSENCE

Name:
Primary Email while on Leave:

LICENSURE INFORMATION			
BC College License #::	License Type:	Will you be maintaining your License while on Leave?	
		Yes	No - Details:
APPLICATION DETAILS			
PHSA Agency:	Department:	Division:	
Leave Type:	Dates Requested:		
Educational      Maternity/ Parental      Personal      Medical      Other	From:	To:	
Provide details for the request:			

\_\_\_\_\_      \_\_\_\_\_  
Applicant Signature      Date

**Note:**

1. This form is for any Medical Staff who will be taking a leave over 30 days for a continuous period of no longer than twelve consecutive months, unless the member is an employee of the health authority in which case leave is governed by the applicable legislation (Bylaws s.4.7.1).
2. This is form is a notice, and not an approval for the Departmental Leave, so is not connected to your pay/benefits etc
3. **Submit a copy of completed form to your Division / Department head directly.**
4. Department will submit the form to the PHSA Credentialing & Privileging office: Fax: (604) 297-9902 or credentialing@phsa.ca

APPROVAL			
By signing below, I am indicating approval for the Leave of Absence request as detailed above.			
Local NP Department Head	_____	_____	_____
	Agency	Leader Name	Signature      Date
PHSA NP Department Head	_____	_____	_____
	Department	Leader Name	Signature      Date
Division Head	_____	_____	_____
	Division	Leader Name	Signature      Date
Department Head	_____	_____	_____
	Department	Leader Name	Signature      Date
<b>Sr. Med Admin APPROVAL only required if initial request is for more than 12 months or an extension to a current LOA beyond 12 months.</b>			
VP Medicine / CMO/ Sr. Med Admin	_____	_____	_____
	Agency	Leader Name	Signature      Date