



MEDICAL STAFF LEAVE OF ABSENCE FORM

A leave of absence must be requested 30 days in advance for any absence from the Medical Staff and/or patient care responsibilities longer than 90 days. A practitioner who wishes to obtain a voluntary leave of absence must provide written notice to the President of the Medical Staff stating the approximate period of time of the leave, which may not exceed one year except for military service or express permission by the SCHS Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill medical staff responsibilities with the exception of completion of medical records.

REQUEST FOR LEAVE OF ABSENCE

Name _____ Date _____
(Please print your name)

I hereby request a leave of absence for the time frame as specified: From _____ to _____

Reason for leave: Personal Medical Educational Other

Please provide details: _____

Signature _____ Date _____

REQUEST FOR REINSTATEMENT FROM LEAVE OF ABSENCE

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the President of the Medical Staff. A practitioner may return from leave on shorter notice than 30 days with approval of the President of the Medical Staff. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or his/her appointment and/or clinical privileges shall lapse at the end of the appointment period. **Failure**, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives.

Name _____ Date _____
(Please print your name)

I hereby request a reinstatement from leave of absence effective: _____

Please provide a summary of professional activities undertaken during the leave of absence: _____

Please note: If the leave of absence was for health reasons, please provide a separate statement addresses any events that may affect the ability to exercise privileges safely and effectively. If returning from a leave of absence for health reasons a report from your physician that answers any questions that the Bylaws and Credentials Committee may have as part of considering the request for reinstatement will be required.

Signature _____ Date _____

Please return the completed form to medicalstaffservices@stcharleshealthcare.org.