Saint Agnes Medical Providers

PROVIDER TIME OFF REQUEST

For ½ day or More

Note: Time off is subject to review and approval. All available time off balances will be used according to time off request type. Additional time off when there is no available benefit balance will be unpaid. Requests for Leave of Absence are coordinated through Human Resources (HR) and follows a separate time off and benefit process.

Name: _____ Department: _____

Requested Dates Starting: _____ Ending:_____ Date of Return: _____

# of days off work: _____

# of PTO Days Available: _____
- ☐ Vacation
- ☐ Sick
- ☐ Other (comment below)

# of CME Days Available: _____
- ☐ Education/Training/CME (attach documentation)

Comments: _____

Name of Provider providing coverage: _____

Signature: _____ Date: _____

Site Coordinator Review for 3 or more days off:

Staffing Plan:

Colleague: _____
- ☐ Taking PTO
- ☐ Available to float (if needed)
- ☐ Flexed / Furloughed

Colleague: _____
- ☐ Taking PTO
- ☐ Available to float (if needed)
- ☐ Flexed / Furloughed

Comments: _____

Signature: _____ Date: _____

Administration Acknowledgement:

Comments: _____

Practice Administrator Signature:_____ Date: _____

Chief Operating Officer Signature:_____ Date: _____

Form date: 5/28/2019