



### REQUEST FOR LEAVE OF ABSENCE

Individual requesting this leave of absence should refer to the Medical Staff Bylaws, Section 2.12 for further information. This completed form should be returned by email to the Credentials and Qualifications Department at [credentials@browardhealth.org](mailto:credentials@browardhealth.org), or alternatively, faxed to 954-473-7255. The request will be reviewed and acted upon, and you will receive notification in a timely manner.

**Full Name:**  
**Department:**  
**Specialty:**

I hereby request a voluntary leave of from Broward Health Hospitals as listed below. I understand that for this request to be approved, I am required to complete any incomplete medical records, return the hospital ID badge, keys, parking gate openers, and any other hospital property to the facility which issued them to me, and that I may not provide any patient care or otherwise exercise any clinical privileges while on a leave of absence.

Date of Request:	
1 <sup>st</sup> or 2 <sup>nd</sup> Year LOA:	<input type="checkbox"/> 1 <sup>st</sup> Year Request <span style="margin-left: 200px;"><input type="checkbox"/> 2<sup>nd</sup> Year Request (only if already on a leave of absence)</span>
Reason for Request:	<input type="checkbox"/> Relocation <input type="checkbox"/> Practice Change <input type="checkbox"/> Contract Change <input type="checkbox"/> Support Services <input type="checkbox"/> Equipment Availability <input type="checkbox"/> Dissatisfaction (explain) <input type="checkbox"/> Other (explain)
Current Appointment Term:	Initial Privilege Date: _____ Privilege Expiration Date: _____ Privilege Status: _____ Staff Category: _____
Primary Facility:	
Other Affiliations:	<input type="checkbox"/> Broward Health Coral Springs <input type="checkbox"/> Broward Health Imperial Point <input type="checkbox"/> Broward Health Medical Center <input type="checkbox"/> Broward Health North <input type="checkbox"/> Community Health Services, Site(s): _____
AHP/Physician Sponsorships:	
Contact Information:	Notification of action will be provided to you at the contact information on record for you unless you wish to provide a different email, fax or address here:
Signature: Sign or Type Name Here	

Notes or Conditions from Facility:	
Approvals: <i>(documented in meeting minutes)</i>	<input type="checkbox"/> Credentials and Qualifications Committee Date: _____ Date: _____ <input type="checkbox"/> Medical Council _____ Date: _____ <input type="checkbox"/> Board _____ Date: _____

- MSO notified CQD of action
- MSO notified practitioner of action
- CQD updated action in database