## Health PEI One Island Health System

## **Leave of Absence Form**

	Surname				Fi	First Name					Employee No.
Data	Department/Division/Worksite				P	Position					Union
	With Pay 🗖 Without Pay 🗖 No. Of Days:				No. C	Of Hours:	Dates	Dates:			Medical Certificate Yes ☐ No ☐
Iliness	Nature of Illness (not Detailed Diagnosis)				or Supervisor verba			Ily advised (Supervisor Signature)			
	Data of First Every				flast Evam				Annuavimete D	-46	Detum
То Ве	Date of First Exam D M Y D				of Last Exam M			Approximate Date of Return D M			Y
Completed by Examining	I, the undersigned, a duly qualified practitioner, hereby certify that I have been in attendance upon or have satisfactory knowledge of the above named person during the illness described above and that he/she was unable to perform his/her duties during the period.										
Physician	Date of Certification D M Y				Physician's Name				Physician's Signature		
Stat Hours	No. Of Days: No. Of Hours:				Dates:	:					
Float Hours	No. Of Days:	No. Of	Hours:	С	Dates:						
Time in Lieu	No. Of Days: No. Of Hours:				Dates:	:					
1					Dates:						
Vacation	No. Of Days:	No. Of	Hours:		Dates:	:					
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