Health PEI
One Island Health System

Leave of Absence Form

Data	**Surname**	**First Name**	**Employee No.**
	Department/Division/Worksite	**Position**	**Union**

Illness	With Pay ❑ Without Pay ❑	**No. Of Days:**	**No. Of Hours:**	**Dates:**	**Medical Certificate** Yes ❑ No ❑
	Nature of Illness (not Detailed Diagnosis)			**or Supervisor verbally advised (Supervisor Signature)**	

To Be Completed by Examining Physician	**Date of First Exam** D M Y	**Date of Last Exam** D M Y	**Approximate Date of Return** D M Y
	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.		
	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:**	**Dates:**
Time in Lieu	**No. Of Days:**	**No. Of Hours:**	**Dates:**
Vacation	**No. Of Days:**	**No. Of Hours:**	**Dates:**

Other Special Leave of Absence	With Pay ❑ Without Pay ❑	**No. Of Days:**	**No. Of Hours:**	**Dates:**	**Collective Agreement Article No:**

Reasons: (Check appropriate areas below)

APPT: EMPLOYEE: ❑ Dental ❑ Medical ❑ Minor Procedure ❑ Travel outside of area (Location)_____

FAMILY MEMBER: ❑ Travel outside of area (Location)_____ (Purpose)_____
Name of Family Member: _____ Relationship _____

❑ Compassionate Leave - Relationship _____

❑ Serious Family Illness - Relationship _____

❑ Family Illness - Name of Immediate Family Member _____ Relationship _____

- Nature of Illness (not Detailed Diagnosis)_____ Medical Certificate: Yes ❑ No ❑

❑ Education - Paid by Employer ___❑_____ Paid by Education Fund ___❑_____

❑ Union Business - Bill Union: Yes ❑ No ❑

❑ OTHER (i.e. Maternity Leave, Personal Leave, etc.)_____

I hereby request leave as indicated above and certify that I was and/or will be unable to report for work for the reasons indicated.

Employee's Signature:	**Date:**

Office Use Only	**Supervisor:**		**Department Head/Designate:**
	Date:	**Approved ❑ Not Approved ❑**	**Reason:**

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