CaroMont Regional Medical Center

Medical Staff
Leave of Absence Form

Name:_____ Specialty:_____

__ I hereby request a leave of absence for the time frame as specified:

Effective Dates of Leave: From_____To_____

Reason for Leave of Absence is: __Personal __Medical __Educational __ Other

Please provide details:_____

_____

Signature:_____Date:_____

**REQUEST FORM FOR REINSTATMENT FROM LEAVE OF ABSENCE**

Name:_____ Specialty:_____

__ I hereby request a reinstatement from leave of absence, effective _____

A summary of professional activities undertaken during the leave of absence is as follows:

_____

_____

__ The leave was taken for medical reasons and I have attached a report from my attending physician indicating that I am physically and/or mentally capable of resuming hospital practice. I further understand that I may be required to provide additional information as may be requested by the Credentials Committee, MEC and/or the Board of Directors regarding my health status.

Signature:_____Date:_____

Fax form to 704.834.2110 or mail to Medical Staff Office, CaroMont Regional Medical Center, PO Box 1747, Gastonia, NC 28053