TRADITIONS BEHAVIORAL HEALTH
PHYSICIAN LEAVE AUTHORIZATION FORM (PLAF)

PART I: DOCTOR

Please fill out the following information. Then have your administrators approve and initial Part II.

1. Date: _____

2. Physician requesting time off: _____
   ☐ Leave **with** pay (includes vacation time, sick time)
   ☐ Leave **without** pay

3. Last day at work before leave: _____ (Date) 4. Day returning to work: _____ (Date)

5. Total hours requested: _____. Days off will include: _____.

6. Total hours accrued: _____, as of: _____ (Date).

7. Rounds and On-Call Coverage to be provided by:

Name	Signature	Facility/Unit	Dates Providing Coverage

8. If more than one physician is covering for you, indicate specifics, i.e. dates/units/rounds/phone, etc.

   _____

   _____

9. Per TBH _____ (Employee Benefits) _____ (Signature) _____ (Date)

PART II: ADMINISTRATORS

Please circle "Yes" if you approve of the requested physician leave, then initial and date.

		Initial	Date
1. Medical Director's Authorization	**Yes / No**	_____	_____/_____/_____
2. Facility Administrator's Authorization	**Yes / No**	_____	_____/_____/_____
3. Facility Administrator's Authorization	**Yes / No**	_____	_____/_____/_____
4. Corporate Medical Director's Authorization	**Yes / No**	_____	_____/_____/_____

PART III:

DOCTOR: When you are finished, fax to TBH at: **(707) 258-0910**.

ADMINISTRATORS: Please provide sufficient advance notice to your units with who is covering, when they are covering, and what their contact office phone numbers and pager numbers are.