Milford Regional Physician Group

The Benchmark for Quality Care

Physician's Request for Time Off

Please use this form as a notification tool regarding time off.
This will ensure employee's schedules are coordinated to meet all of the organizations needs.

I, Dr._____, will be off during the period of time from

_____ to _____.

I understand that I am responsible to arrange for coverage during my absence. I have discussed my requested time off with the Site Director.

_____ _____

Signature of Physician Date

_____ _____

Office Manager Acknowledgement & Review with Practice Manager Date

_____ _____

*Signature of CEO if applicable Date

This form must be returned to your Practice Manager a minimum of 2 weeks prior to scheduled time off where foreseeable

*Any scheduled absences in excess of 10 consecutive scheduled working days will require written approval by the C.E.O. at least 1 month in advance.