

# Provider Leave Authorization Form (PLAF)

TRADITIONS BEHAVIORAL HEALTH

## Part I: Doctor

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

II.	Name	Type of Leave		
		Leave WITH pay (PTO - vacation or sick time)	Leave WITHOUT pay	
Last Day of Work	Days Requested Off		Day Returning to Work	Total Hours Off
	to			

If you give TBH less than three months notice, you are responsible for arranging coverage.

Rounds and On-Call Coverage to be provided by:

Covering Physician / Provider Name	Phone number	Signature	Facility / Unit	Dates Providing Coverage
				to
				to
				to
				to
				to

Physician/Provider Signature

E-Mail (to receive confirmation)

Date

## Part II: Administrator(s)

Administrator(s): please check "Yes" if you approve of the requested provider leave, then sign and date. Please provide sufficient advance notice to your units with who is covering, when they are covering, and their contact phone/pager number.

Facility / Unit	Approve?	Administrator Signature	Date
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		
	<input type="checkbox"/> Yes <input type="checkbox"/> No		

## Part III: TBH

Doctor/Provider: When you are finished, fax to TBH.

**Fax: (707) 253-0457**

TBH Staff

Date