
Hospital Leave of Absence Form

Patient Details

- Name: _____
- Patient ID: _____
- Doctor's Name: _____
- Department: _____
- Contact Number: _____
- Email Address: _____

Leave Details

- Reason for Leave:
 - ☐ Surgery
 - ☐ Recovery
 - ☐ Treatment
 - ☐ Other: _____
- Start Date: _____
- End Date: _____
- Total Days: _____

Doctor's Recommendation

- Details of Required Leave:

- Doctor's Signature: _____
- Date: _____

Patient/Guardian Acknowledgment

I understand the hospital's leave policies and agree to comply with all requirements.

- Patient/Guardian Signature: _____
- Date: _____

Hospital Administration Use Only

- Approved: ☐ Yes ☐ No
- Approved by: _____
- Remarks: _____
- Date: _____