

SENIOR MEDICAL STAFF
(Consultants, Associate Specialist, Staff Grade, Specialist Nurses)

NOTIFICATION OF ANNUAL LEAVE (giving a minimum of 8 weeks notice)

Name **Base Hospital**

Grade **Speciality**

First day of absence	Date of return to duty	Number of working days on annual leave	Name of Consultant Colleague covering during period of leave

Signed **Date**

I have worked the following public holidays

COLLEAGUE COVER

I can confirm that the arrangements for cover have been discussed with me and I have agreed to provide the necessary patient care during the absence specified above.

Signed **Date**

N.B. When a Locum is required please submit Annual Leave requests not less than twelve weeks prior to the proposed date of departure

FOR COMPLETION BY THE GENERAL MANAGER

To

Your application for leave from to has been approved / not been approved (**please delete as applicable**)

If not approved reason

Your balance of annual leave following this application until is

Annual Leave days **Lieu days**

Signed **Date**

Designation

NOTE

Your annual leave is calculated on a five day week basis i.e. 6 weeks x 5 days = 30 days per annum. However, please indicate on your annual leave form the weekends you intend being away.

TERMS AND CONDITIONS OF SERVICE FOR HOSPITAL MEDICAL AND DENTAL STAFF

Your attention is drawn to paragraph 215 which states “Practitioners shall notify their employing authority when they wish to take annual leave, and the granting of such leave shall be subject to approved arrangements having been made for their work to be done during their absence”.

Paragraphs 108 – 111 provide for the employment of Locums where it is not possible for practitioners to deputise for an absent colleague.

Clinics/Theatres that will be affected due to requested leave

Date	<u>Theatre</u> Session	Clinician name	Time (am/pm)	Request Details (To cancel, reallocate, etc)	Outcome (cancel, change of surgeon, reallocation etc)

If clinical session request is with less than 8 weeks notice, please state below what alternative arrangements have been made to cover the clinical session:-

Date	<u>Clinic</u> Code	Clinician name	Time (am/pm)	Request Details	Outcome (cancel, change of surgeon, reallocation etc)

If clinical session request is with less than 8 weeks notice, please state below what alternative arrangements have been made to cover the clinical session:-