

**EXTENDED LEAVE NOTIFICATION FORM
(FOR ABSENCES OF TWO WEEKS OR MORE)**

PATIENT INFORMATION	
Patient Name (Last, First)	Date of Birth
Contact Name	Relationship to Patient
Home Address	
Cell Phone Number	Alternate Phone Number
Email Address	
INFORMATION REGARDING EXTENDED LEAVE	
Leave Start Date	Return Date
Missed Appointment Dates, Times, and Disciplines	
Additional Information	
Initial the below statements and sign indicating your understanding and acknowledgement:	
_____	I understand Circle Creek Therapy's Attendance Policy.
_____	I understand that in the event of an extended leave of more than two weeks, in order to save my permanent appointment time, I must pay a non-refundable \$40 holding fee per session or forfeit my permanent appointment slot.
_____	I understand that if my leave is extended past the above dates, and I do not notify the Circle Creek Therapy office (253.237.3405), my permanent appointment slot may be canceled.
Signature	
Printed Name	Date

OFFICE USE ONLY

Clinician(s) _____

Clinician(s) notified: _____

Office notified: _____

Holding fee collected \$ _____ OR no holding fee collected by _____ on _____