TORRANCE MEMORIAL | An Affiliate of Cedars Sinai

REQUEST FOR LEAVE OF ABSENCE

NAME: _____

(Please print)

HOME ADDRESS: _____

_____

HOME PHONE: _____ **HOME FAX:** _____

CELL PHONE: _____

EMAIL ADDRESS: _____

Please check the appropriate box. I am requesting a Leave of Absence due to:

☐ **MEDICAL** _____
Please explain

☐ **PERSONAL** (Non-Medical)

☐ **OTHER** _____
Please specify: i.e. additional training

Start Date: _____

Signature: _____

PLEASE EMAIL THE COMPLETED FORM TO: _medicalstaffservices@tmmc.com
(PLEASE NOTE THERE IS AN UNDERSCORE AT THE BEGINNING OF THE EMAIL ADDRESS)
THE MEDICAL STAFF OFFICE
3330 Lomita Boulevard • Torrance, CA 90505-5073 • 310-517-4616 Phone