



Independent Health Care Service

Leave Notification Form

Leave Entered on Data Base

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Staff Name: _____

Leave Dates: From: ____/____/____ To: ____/____/____

Signature: _____ Date: _____

Replacement Information Details- staff member to complete						Office to Complete			
<input type="checkbox"/> Annual Leave <input type="checkbox"/> Sick Leave <input type="checkbox"/> Parental Leave <input type="checkbox"/> LLSL <input type="checkbox"/> Carers Leave <input type="checkbox"/> Permanent Change <input type="checkbox"/> Other _____					Task Eg HGM, Med Prompt, P/C, D/A, Meal prep	New time	Staff Replacement	Client Informed	
Client's Full Name	Day	Date	Times	Code	P/C/Letter Carer/Msg			Initial & Date	

Approved by: _____

Signature: _____

Date: _____

Entered onto Leave Tracking Form in Personnel File

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Signature: _____

Date: _____

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