**Washington Physicians Health Program**
**(206) 583-0127 or 800-552-7236 Fax: (206) 583-0418**

# EXCUSED ABSENCE FORM

Name: _____ WPHP Participant ID#:_____
(Please print)

Group Location: _____ Day: _____ Time: _____
(City)

Please accept this letter as written notice of my planned absence from:
**GROUP** on the following date(s): (**LIST <u>ONLY</u> DATES OF MISSED GROUPS**)

_____

**UA's** on the following date(s): (**LIST <u>ONLY</u> DATES OF MISSED UAs)**

_____

The reason for this absence is:

_____

_____

My phone number during my absence is: (_____) _____

**Weekly: I recognize that I may have up to six excused absences from group per year and this absence will be my (#) _____ excused absence this calendar year.**

**Monthly: I recognize that I must attend one group per month. If I must be excused, I need to schedule a makeup meeting with my clinical coordinator.**

This notice is provided to WPHP staff at least one week in advance and I have notified my peers in group of this planned absence at least one week in advance. Further, I recognize that if there are mitigating circumstances which I feel require special consideration I will bring these circumstances to the attention of the WPHP staff and these will be handled by the WPHP staff on a case-by-case basis.

If there are any questions you have regarding this request for an excused absence, please contact me at (____)_____.

_____ _____
WPHP participant signature Date

_____ _____
Facilitator approval WPHP Staff approval

For Office Use: Date of Missed UA: _____ Make Up Date:_____