INSTITUTE OF COMMUNITY AND FAMILY HEALTH, INC.
4th Floor, Medical Arts Building, Fe del Mundo Medical Center
11 Banawe corner Cardiz Streets, Barangay Doña Josefa, Quezon City 1113
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Cellfone number: +639059454511 / Landline number: +63284206770

LEAVE OF ABSENCE FORM

Date: _____

Name: _____

Year Level: _____

Purpose for Leave:

_____

_____

Date of Leave: From _____ To: _____

Number of Days/Weeks/Months (Not to exceed one academic year): _____

Type of Leave: ❒Medical. ❒Others, please specify: _____

(Please attach any supporting document if applicable. No leave will be granted in less than two weeks before the last day of classes during the semester).

TO BE FILLED OUT BY THE ADMINISTRATION

Class Standing: ❒ Passing ❒Failing

Received by: _____ Date: _____
Printed name and Signature
School Registrar

Amount of Money Refunded to Student: Php _____

❒Approved ❒Disapproved

Reason for Disapproval: _____

_____

Approved by: _____ Date: _____
ELSIE LYNN B. LOCSON, MD, MPH, MSc, FPPS
Executive Director and Dean, ICFH