Vacation / Leave of Absence / Sabbatical Request Form

☐ **Vacation**

☐ **Leave of Absence** (up to 6 mo)

☐ **Leave of Absence Extension** (6 mo - 1 year)

☐ **Sabbatical** (over 1 year or up to 2 years)

To be completed by the Heraya Provider requesting absence:

Name of Heraya Provider Requesting Absence:		Discipline: (circle one) DC ND LAc LMT	
Reason for Absence:	Number of Days:	From:	To:
Have you reviewed the policy of Vacation/ Leave of Absence policy?		Yes ☐	No ☐

Call Coverage Request

Are you requesting call coverage?	☐	Yes	☐	No	If yes, complete section below.		
Name of Call Coverage Provider:					Provider's Office Phone:		
Provider's Business Address		City			State	Zip	
1. Is the provider currently on the Heraya network?					Yes	☐	No
2. Will you be available to the provider or Heraya during your leave?					Yes	☐	No
3. I understand the following with respect to Call Coverage: • Call coverage, once approved, is allowed up to 90 days • Call Coverage providers may not treat specified members references in policy 3.06 • Please refer to the Provider Operations Manual and: • Read the Call Coverage policy 1. Submit the Call Coverage Application, to be completed by the covering provider via fax to 877-482-2856					Yes	☐	No

Requesting Provider Signature: _____ Date: _____

Submit Request (and questions if any) to Heraya in any of the following methods:

- Email: ps@herayahealth.com
- Fax: 877-482-2856
- Mail: 6600 SW 105th Avenue Suite 115, Beaverton, OR 97008