**Department of Internal Medicine**

**Clinic Cancellation Request Form**

*To ensure continuity of care and maximize efficient use of ambulatory care resources, every effort should be made to avoid clinic cancellations. If you do need to cancel a clinic - the “Clinic Cancellation Request” form must be submitted to the Manager of Patient Care for that clinic,* ***a minimum of 30 days in advance. All clinics cancelled with less than 30 days notice must be approved by the Section Head.***

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| Physician’s Name: *(Please Print)* | Clinic: General Hepatology |
| Date of Clinic Cancellation: | Clinic Site: HSC [ ] SBGH [ ] Grace Hospital [ ] VGH [ ]  |
| Rationale for Cancellation: |
| **Physician’s Signature** | Date: |
| Name of Manager of Patient Care | Date Request Received by Manager of Patient Care: |
| Manager of Patient Care’s Signature | Date: |
| Cancelled Clinic Time Assigned To: |
| Section Head Approval: *(If less than 30 days notice received, Section Head approval is required)*Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |