# TEMPORARY DISABILITY LEAVE OF ABSENCE REQUEST

Requests for temporarily disabled status must be accompanied by signed documentation from a licensed physician.

Please email the completed form to info@mdcb.org.

Name _____ MDCB # _____ Date _____

Address _____

City _____ State _____ Zip _____

Email _____ Phone _____

☐ **I understand it is the professional responsibility, as outlined on the MDCB website, for each CMD to maintain current contact information on file with the MDCB, submit the renewal fee by December 31st of each calendar year and complete and submit 50 continuing education in each five-year cycle.**

☐ **I have read, understand and agree to the policy outlined at https://mdcb.org/cmd-credentialing/temporary-disability-leave-absence.**

Brief explanation of reason for request:

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