## **FORM E**

## THE COUNCIL FOR PROFESSIONS SUPPLEMENTARY TO MEDICINE Notice of Impending Absence

Miss. /Mrs. /Mr				
	(Name)			
of				
	(Address)			
	(Adaress)			
Will be absent from practice from		_to		
	(Date)		F (Date)	
Profession:				
C				
E-mail Address:				
Tel no's:				
*				
Signature:				