# Provider Clinic Session Cancellation Request Form:

**Date Request Made:** ________________ **Name of Requestor:** _______________________

**Dates to be changed or canceled:** _________________________________

**AM** ____ **PM** ____ **BOTH** ____

Based on the Care Access Standards, any physician or mid-level provider canceling a clinic session within **7 days** of requested date, must receive approval and signature from CMO. All other requested clinic cancellations must be submitted via the Cancellation Request Form, with the appropriate signatures. The Cancellation Request Form must be submitted to the Care Access team to complete the patient cancellation process.

**Reason for clinic session cancellation:**

Vacation __ Academic __ Administrative __ Medical __ Educational Leave __

Attending Duties __ Other: _______________________________________________

***Important Notes for Care Access scheduling and/or administrative team to know about rescheduling patients:***

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

*Once completed and signed, send a scanned file to CareAccessDepartment@health.southalabama.edu for processing of the template change request.*

___________________________ Physician Signature

___________________________ Faculty Chair Signature (if necessary)

___________________________ Director of Operations Signature

___________________________ Date

___________________________ CMO Signature (if 7 days or less)

***For Care Access Template and Capacity Management Liaisons Only:***

Request received on: __________ Request applied on: ___________

Completed by: ________________________________________