# LEAVE OF ABSENCE FORM

ESSA
EXERCISE & SPORTS SCIENCE AUSTRALIA

## SELECT ACCREDITATION TYPE TO BE PLACED ON A LEAVE OF ABSENCE

- Accredited Exercise Physiologist (AEP) (including AES)
- Accredited Exercise Scientist (AES)
- Accredited Sports Scientist (ASpS)
- Accredited High Performance Manager (AHPM)

If you wish to maintain your Full membership while your accreditation is on a leave of absence (LOA), please notify ESSA on submission of this form.

Practitioners wishing to take a break from the exercise physiology, sports science, exercise science professions are able to take a leave of absence from their accreditation. Practitioners are required to read and understand the Recency of Practice Policy and Return to Practice Policy prior to applying for a leave of absence.

For further queries please call (07) 3171 3335 or email info@essa.org.au

## PERSONAL DETAILS

Title First name Last name

ESSA ID Contact phone number

Email

## LEAVE DETAILS

Commencement of leave date

Please select the primary reason for taking a leave of absence:

- Maternity Leave
- Parental Leave
- Illness
- Change of Career
- Holiday
- Moving overseas
- Completing further study
- Accreditation no longer required for employment
- Government mandates
- Other

*Please note: Leave of absence dates cannot be backdated unless you are currently unfinancial. Accreditation/ Membership fees are non-refundable. Credit to future billing may be applicable if reinstating within 2 years.*

## ANNUAL ACCREDITATION REQUIREMENTS

Annual accreditation requirements still apply for the time you are accredited, including Continuing Professional Development (CPD) Points.

- I acknowledge I am required to fulfil CPD requirements for the time I held accreditation this calendar year.

## DECLARATION

I understand there are requirements to reinstate my accreditation as stipulated within the Recency of Practice Policy and Return to Practice Policy.

I understand I will not have access to the Members Lounge and Member Benefits, unless remaining a full member.

I understand regulatory bodies will be advised of my leave (if applicable), and as a result, my provider status will lapse. I understand it is my responsibility to contact Medicare to reinstate my provider status upon reinstatement.

| Signature | Date |
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