PHYSICIANS TO Women INC.

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DISABILITY AND FAMILY MEDICAL LEAVE FORM REQUEST

The following information is needed to complete your disability of FMLA request completely.
Please complete this information sheet and submit it along with all forms to be completed. Thank you.

Date _____/_____/_____

Patient's Name_____ Date of birth_____/_____/_____

1. Please check one of the following: ☐ Pregnancy ☐ Surgery ☐ Other_____

_____

2. Your physician at Physicians to Women: _____

3. Date you were taken off work:_____/_____/_____

4. Date you were admitted to the hospital (if admitted):_____/_____/_____

5. Date you were discharged from the hospital:_____/_____/_____

6. Date you expect to return to work, or weeks you are expected to be out of work: _____

_____

7. Will you have any restrictions or limitations when returning to work? If yes, please explain_____

_____

8. If forms are for a family member, please give the **name and relationship** and the dates the family member will be out. Please include the first day out of work and estimated return to work date. _____

_____

9. Where are we to send the completed forms?

☐ Mail to: _____

☐ Fax to: _____

☐ Pick up at office. Number to call when completed: (_____) _____-_____

There is a $25 charge for each Disability and FMLA form completed.

FORMS WILL BE READY IN FIVE (5) BUSINESS DAYS FROM DATE RECEIVED

IF THIS FORM IS NOT COMPLETELY FILLED OUT IT WILL CAUSE A DELAY

Updated 10/9/12