The Women's Health Group

DISABILITY/FMLA FORM REQUEST

Obstetrics & Gynecology

Because of the excessive paper work that some companies (employers and insurance companies) are demanding, we charge $25.00 for the completion of each set of Disability or FMLA form. We require 48 hours to complete this form.

Please answer the following questions in order to allow us to complete your form:

Print Patient Name: _____

Patient Date of Birth _____

For Office Use ONLY:

Dr. Name: _____

Date Paid: _____

Initials: _____

Which option are you requesting at this time?

☐ Letter with all pertinent information – **DISABILITY ONLY** (No Charge)

☐ Fill out your complete form ($25.00 charge)

Reason for Disability / FMLA:

☐ Maternity Leave ☐ Pregnancy Complication ☐ Surgery ☐ Other_____

MATERNITY LEAVE *(Usually a period of 6 weeks for vaginal & Cesarean Delivery)*

Date of last menstrual period:_____Estimated delivery date:_____

Are there any complications requiring you to stop working before your delivery date? ☐ Yes ☐ No

If yes, please explain_____

Last day at work_____Date returning to work_____

SURGERY

Type of surgery_____Date of surgery_____

Last day at work_____Date returning to work_____

OTHER

Reason for disability_____

Last day at work_____Date returning to work_____

IF HOSPITALIZED:

Name of Hospital_____

Admit Date_____Discharge Date_____

☐ Mail completed form to:_____

☐ Patient will pick up form on_____

"I authorize The Women's Health Group, its representatives and agents, to release all information requested in my Disability or FMLA form to the company named above. I understand and agree to pay the $25.00 charge for form completion."

_____ _____

Patient Signature Date