The Women's Health Group

DISABILITY 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 disability form. You have a choice of obtaining a letter stating your condition and dates of disability at no charge or paying the $25.00 charge to have your form completed. 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 _____

Which option are you requesting at this time?

☐ Letter with all pertinent information (at no charge) ☐ Fill out your complete form ($25.00 charge)

Reason for disability:

☐ 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 form to the company named above. I understand and agree to pay the $25.00 charge for form completion."

_____ _____

Patient Signature Date