



FMLA FORM REQUEST
Obstetrics & Gynecology

Because of the excessive paper work that some companies (employers & insurance companies) are demanding, we charge \$25.00 for the completion of each FMLA form. We require 48 hours to complete this form. Please bring completed form with your forms and payment to the office.

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

Reason for FMLA:

- Appointments / Testing
- Pregnancy Complication
- Maternity Leave
- 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 _____

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

Patient Signature

Date

Print Patient Name

Patient Date of Birth