



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 at least 5 business days to complete this form. They are completed in the order received.

Please answer the following questions. Incomplete forms will delay completion.

Print Patient Name: _____

Patient Date of Birth _____

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 6 weeks for vaginal, 8 weeks C-Section. Employer may grant more.)

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 or Fax to: _____

☐ Patient will pick up form on _____

*We are not able to email completed forms.

"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

For Office Use ONLY:

Dr. Name: _____

Date Paid: _____

Initials: _____