FMLA / DISABILITY PAPERWORK COVER SHEET

(a separate cover sheet must be completed for each set of FMLA/disability paperwork)

PATIENT NAME PRINTED: ____________________________DATE OF BIRTH: _____________________

PHYSICIAN: ____

FORMS BEING COMPLETED FOR: ☐SELF ☐SPOUSE ☐OTHER: ______________________

****PLEASE ALLOW 10 BUSINESS DAYS FOR COMPLETION OF FORMS****

THANK YOU!!

DATES YOU ARE REQUESTING OFF:

Continuous dates (if required): FROM: ______________ TO: ______________

Intermittent / Hours / Dates (if required): ______, ______, ______, ______, ______

Date you plan to return to work: ____

REASON:

Date of delivery: __________ Type of Delivery: _______Vaginal _______ Cesarean

Which Hospital did you deliver at? ____

Other surgical procedure: _________________________ Hospital: _________________

Date of hospital admission: _____________Date of hospital discharge: _______________

Last date worked: ____

HOW WOULD YOU LIKE US TO HANDLE YOUR COMPLETED FORMS?

Pick up: __________ Phone # to call when completed: _______________________

Fax to: Fax # __________________________ Attn: ______________________________

Mail to this address: _______________________________________

____

____

Other: ____

____

- -

SECTION BELOW FOR OFFICE USE ONLY: **DATE RECEIVED: _________**

PATIENT NAME: ___________________________________ACCT #______________________ INITIALS: ______

PAID $_______________ METHOD: ☐CASH ☐CK#________ ☐CREDIT/DEBIT ☐CREDIT ON ACCT

NURSE COMPLETING FORMS: _________________________ DATE COMPLETED: ___________________