FMLA / DISABILITY FORM REQUEST

Patient Name: _____ Patient Number: _____

Patient Date of Birth: _____ Usual Provider: _____

- Forms must be brought to the office and payment is due at that time. Forms received via fax or mail may cause delay.
- There is a fee for ***each*** form that needs to be completed.
- The form is typically completed within 7-10 business days from date of payment.
- Please ensure that you have only completed the "patient" portion of your form. We are unable to submit forms in which the "physician/provider" portions have been completed (even in part) by someone other than an Alliance Ob-Gyn staff member.
- Forms are completed for medically indicated time off work ONLY. Any additional time that you are eligible for under FMLA must be coordinated by you and your employer.

Patient Signature: _____ Date: _____

1. If form is for another family member or caregiver of patient, indicate name and relationship to patient:

   _____ _____
   Name Relationship

2. What is the reason for your disability?
   - ☐ Pregnancy ☐ Surgery
     - ☐ Vaginal ☐ C-Section

   Do you require leave for one or both of the following:
   - ☐ Intermittent Leave
   - ☐ Post Delivery

3. Date you stopped working: _____
4. What was your delivery date or expected due date: _____

NOTE: _____
Use additional sheet if necessary.

Once form is completed, how would you prefer we process?

- ☐ Fax Fax to: _____
- ☐ Mail Form Mail to: _____
- ☐ Pick Up – Patient will request upon arrival at Check In desk.

For internal use:

# of forms:	_____ x $10	=	_____	☐ Paid	☐ Update Only – No charge ☐ No Charge – Other (manager approval)
Date received	_____	By:	_____		
Message Sent to MA	_____	By:	_____		
Form completed on	_____	By:	_____	☐ Faxed	☐ Mailed
Scanned to chart on	_____	By:	_____		
Patient notified on	_____	By:	_____		