FMLA / DISABILITY CHECKLIST

Patient Number: _____

Usual Provider: _____

Dear Patient:
Please be advised that there is a fee for ***each*** form that needs to be completed, payment is due when forms are dropped off. The form is typically completed within 7-10 business days. Please answer the following questions in order to ensure accuracy of documentation. Please ensure that the form you are submitting is BLANK. We are unable to submit forms that have been completed (even in part) by someone other than an Alliance Ob-Gyn staff member.

1. What is patient's full name? _____

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

   _____ _____
   Name Relationship

2. What is your date of birth? _____

3. What is the reason for your disability? (Circle One)

   Pregnancy Surgery Other: _____

   Does it need to include intermittent time off for Alliance OB/GYN appointments? YES NO

4. What physician performed your delivery/surgery? _____

5. Date you stopped working: _____

6. Date you anticipate returning to work: _____
   *Your anticipated return to work date may be changed by your physician.

7. What was your delivery date or expected due date: _____ ☐ Vaginal ☐ C-Section

8. What type of surgery was performed? _____

9. What type of work do you do? _____

10. Who is your employer? _____

11. What concerns do you have about returning to work? _____

    _____

12. Anything else we should know? _____

    _____

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

    ☐ Will Pick Up Contact Number: _____
    ☐ Fax Fax to: _____
    ☐ Mail Form Mail to: _____

Patient Signature: _____ Date: _____

FOR OFFICE USE ONLY #of Forms: _____ x $10.00 = _____

Date Received: _____ By: _____

PAID: _____ CASH CHECK #_____ CREDIT ____

Payment Collected _____ YES _____ NO

Added to W Drive: _____

Date Form(s) Completed: _____ By: _____

Method of Communication to/for patient:

_____ Faxed _____ Mailed _____ Patient Notified P/U

Date Communicated: _____ By: _____

Date Patient will P/U (if applicable):_____

Copy(s) made of each form(s): _____

Date submitted to Scanning: _____
Date submitted to Scanning: _____