FMLA / DISABILITY FORM REQUEST

Patient Name: _____ Patient Date of Birth: _____

Usual Provider: _____ Patient MRN: _____

Forms for (name): _____ Relationship to Patient: _____
(If different than patient)

- There is a fee for ***each*** set of forms that needs to be completed.
- The form is typically completed within 7-10 business days from the 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.

What is the reason for your disability? ☐ Pregnancy ☐ Surgery

Due Date: _____ Date of Surgery: _____

What type of leave? ☐ Intermittent Leave ☐ Post Delivery

Have you stopped working? _____ If yes, indicate last date of work: _____

☐ Form completion due date: _____

NOTE:

Once the form is completed, we will send you a text message to inform you it is available to be picked up. If you need it sent by an additional method, please indicate below:

☐ Fax Fax to: _____
☐ Mail Form Mail to: _____
☐ Pick Up
☐ Original Forms Required

Patient Signature: _____ Date: _____

For internal use:

☐ Paid
☐ Update Only – No charge
☐ No Charge – Other (manager approval)
☐ Credit on account

# of forms:	_____ x $10	=	_____
Date received	_____	By:	_____
Message Sent to MA	_____	By:	_____
MA Completed	_____	By:	_____

Notes: