Date:				
In order to ensure your	form is complete	ed correctly, pl	lease fill out this	s worksheet.
Due to the complexi signatures this proc	ty of the form, ess takes 10-14	the informa 4 business o	tion required lays.	and physician
Please be sure that the and signed by you.	employee section	of your disabi	lity or FMLA fo	orm is filled out completely
Our new policy states a expected when the form this fee has been collect	n is left at the offi	o will be asses ce for complet	sed to complete ion. This form v	e each form. Payment is will not be completed until
Patient Name:				
Date of Birth:/_	/	Physician:		
Is this form for someone	e other than the J	patient? YES	or NO	
If so: Name of Person R	equesting paperv	work and Relat	ionship to patie	ent.
Name			Relationship to	o Patient
Are You Requesting: □	FMLA <u>(Questi</u>	ons 1-5-BLO	CK OF TIME	ONLY)
	Intermittent Le	ave-FMLA (Sl	cip Questions 1-	5)
	Short Tem Disa	bility		
	Insurance Bene	efit such as AF	LAC	
	Other, Please sp	pecify type of f	orm:	
work(i.e. hosp 1. First DATE you v	italization)	, the infor	mation be	
2. Date returned or	expected to return	rn to work:		
3. Brief Job Descrip4. Recently Hospita	otion:	To Data/s:		
5. Have you follow	ved up with you	r nhvsician si	nce discharge	d from the hospital?
	es or No If N			
6. Name & Specialty	y of other treating	g physicians, P	lease list:	*
When ready:				
Please CallName	@	Phone #	_Pick Up @	Location
Fax toName/Comp				
Name/ Comp	any		Ι	Fax #
Comments:				
****				Thank You
Office Staff: Check #	Åmt \$	Credit Car	⁻ d Amt \$	Cash Amt \$
Received By:	Location	C1-1-	d n	0.1.