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Obstetrics and Gynecology
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Disability Forms Request
(PLEASE PRINT)

Please fill out very carefully so your forms are completed properly.

Date: _____

Patient Name: _____ Date of Birth:_____

Phone #: _____

1) Are the forms for ☐ PATIENT -or- ☐ SPOUSE (check one)

2) Reason for forms ☐ Surgery/Recovery ☐ Delivery ☐ Intermittent leave for prenatal care or illness or ☐ Other: _____
****Please note… your FMLA forms cannot be filled out for intermittent leave and continuous leave at the same time.**

3) For SURGERY or DELIVERY: Were you admitted into the hospital? ☐ YES ☐ NO (check one)
If YES – what are the dates you were admitted and discharged? _____
What hospital were you admitted to? _____

4) DATES you want on form: Last Day Worked: _____ Return to Work Date: _____
DUE DATE: _____ Actual Date of Delivery: _____ ☐ Vaginal or ☐ C-Section?
Other Dates you need on forms and reason _____

5) Do you want the forms faxed when completed: ☐ Yes ☐ No (please see cost of faxing below)

Form Fee is $15 per set of forms and payment is due when you drop off the forms. You are responsible for the fee if your disability company faxes forms to the office on your behalf. Please allow up to 7 business days for completion of forms.

We will fax your forms to the disability company provided for an additional fee.
The fax fee is $2 up to 10 pages and $3 up to 20 pages.

For Office USE: # of sets of forms: ____ Paid: $_____ Date:_____ Login Name
Fax Fee paid $ _____
BWC2015