PATIENT REQUEST FOR DISABILITY/FMLA FORMS/INSURANCE FORMS

Dear Patient,

Our office is happy to assist you in completing your disability/FMLA/Insurance Paperwork. Please answer the following questions to help us expedite the process. Please note the patient portion of the paperwork **must be filled out prior** to turning it into our office.

Prior to completing these forms we require a payment of $25

Please allow 5-7 business days for completion

Thank you for your assistance.

1. Patient Name: ____
2. Date of Birth: ____
3. Phone #: ____________________________
4. Please list specific dates you are requesting off: ____________________
5. List the reason for the time off and any job requirements you are unable to perform. (ie, no heavy lifting, no bending, etc)

   ____

6. Once completed, where do you want these forms sent?
   a. Mail to Patients Home Address: ______
   b. Employer's FAX #: ________
   c. Patient will pick up: ________