# FMLA AND DISABILITY FORM REQUEST

To our patients:

You, your employer, or your insurance company has requested that our clinic give out information for the processing of FMLA and or disability benefits. **We ask that you understand that it may take at least 7-10 business working days to complete this request.** We only list periods of time off work estimated for medical reasons**.** Employee benefits questions need to be directed to your employer or their benefits representative.

**Prepayment is required for processing disability forms at *$15.00 per form*. Checks are to be made payable to: The Women's Clinic of Vancouver, P.S.**

To be sure we have the information needed for completing our medical portion of the form(s) regarding your disability, please complete the following questionnaire, sign and date it.

**1.** Patient's Name: _____last 4 of SSN:_____DOB: _____

**2.** Employee's name: (if different) _____Relation to Patient_____

**3. Please check one of the 3 areas below and complete the section *(how you use your employment benefits for vacation or sick time will not be specified by a physician)*:**

____**MATERNITY LEAVE : (6 weeks is the normal length of time for vaginal delivery)**
Estimated date of delivery _____

***Are there complications you feel are requiring you to stop working before your delivery date?*** _____
*If you answered "yes", please explain:* _____

____**INTERMITTENT LEAVE**: _____Hrs per week OR _____ days per week
Starting date of intermittent leave: _____
**Reason** for intermittent leave: _____

_____ **SURGERY** _____
***Last day worked:*** _____ ***Estimated Date you plan on returning to work:*** _____

**4. INFORMATION RELEASED TO**:
_____
***Name of employer, short term disability company and or other entity which you authorize to receive your medical information.***

____**FAX** form to *fax* #:_____ ***Attn. to***_____

____**CALL** when completed for patient to pick up: #_____

____**MAIL** form(s) to: _____

**"I authorize The Women's Clinic of Vancouver, P.S., its representatives and agents to release all information requested in my disability form to the company named above. I understand there will be a charge for completion form and agree to pay the $15.00 fee prior to the release of the completed form from the clinic."**

**5.** _____ _____
**Signature** **Date**