

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 \$25.00 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: _____ 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: _____
What date are you planning to stop work _____

____ 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 of the form and agree to pay the \$25.00 fee prior to the release of the completed form from the clinic."

5. _____
Signature

Date