COMPREHENSIVE
WOMEN'S HEALTHCARE

DISABILITY FORM / FMLA FORM

Patient Name: _____ DOB: _____

Which Company is requesting the form: _____

CIRCLE ONE: Disability OR FMLA

Please mark your selection of how you would like the completed forms to be returned to you:

☐ **Please call when the form is ready for pick-up.**

OR

☐ **Please fax the completed form to fax#** _____

What is the reason you need disability / FMLA paperwork filled out _____

_____

_____

_____

Dates you are requesting disability /FMLA _____ to _____

Who is the treating Physician for this medical problem: _____

PLEASE <u>INITIAL & SIGN</u> ALL AREAS BELOW:

_____ **You have already completed your portion on the disability form that is required by the patient to complete.**

_____ **You have paid your $20 form fee.** **$25.00 Paid _____ /Date Paid: _____**
(CWH Staff Initials)

_____
Patient Signature

_____
Date