

Disability and Family Medical Leave Form

The following form is needed to complete your disability or FMLA request correctly. Please complete this information sheet and submit along with all forms to be completed. Thank you.

Date: ___/___/___

Patient Name: _____ DOB: ___/___/___

1. Please check one of the following:

Pregnancy Surgery Other (Please explain below.)

2. Your physician at Western Virginia OB/GYN Center: _____

3. Date your were taken off work: ___/___/___

4. Date you were admitted to hospital (if applicable): ___/___/___

5. Date discharged from hospital (if applicable: ___/___/___

6. Date you expect to return to work or weeks you are expected to be out of work:

7. Will you have any restrictions or limitations when returning to work? Please explain.

8. If forms are for a family member:

Your name: _____ Relationship: _____

Dates family member will be out of work: _____

First day out of work: ___/___/___

Estimated return to work date: ___/___/___

9. Where do you want the completed forms to be sent?

Mail Address: _____

Fax: Fax No: _____

Person to receive fax: _____

Pick up at office: Number to call when complete: _____

There is a \$20.00 charge for each disability form. There is no charge for Family Medical Leave forms.