

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

## **FMLA/DISABILITY FORMS**

Due to the high volume of request for our office to complete FMLA/Disability forms for leave of absence (maternity, surgical, etc.). It has become necessary to charge a **\$25.00 administration fee** to complete these detailed forms. Payment is collected at the time your disability forms submitted to our receptionist. No payments via phone accepted. Payment is not billed by our office to the insurance company. **Disability forms must be submitted 30 business days prior to the deadline**. The receptionist will take the form, with the employee portion completed including beginning date of leave and return to work date. Incomplete forms will not be accepted.

**Our office will NOT fax, email or mail completed disability forms.**  
**We will call you when forms are completed and ready to be picked up.**

Patient must provide the following dates:

Start date of leave: \_\_\_\_\_

Return to work date: \_\_\_\_\_

**DISABILITY FORMS WILL BE COMPLETED AND READY FOR PICK UP IN 15 BUSINESS DAYS FROM THE DATE DISABILITY FORMS WERE RECEIVED AND PAID FOR.**

I acknowledge, and hereby authorize Woodlands Women's Care to release any of my protected health information pertaining to my medical leave.

I hereby authorize Woodlands Women's Care to release and discuss any of my protected health information pertaining to my medical leave with my employer.

Employer Name: \_\_\_\_\_

\_\_\_\_\_  
Patient Signature

Date forms received, and payment made: \_\_\_\_\_

employee signature: \_\_\_\_\_