Northwest
OBSTETRICS & GYNECOLOGY

DISABILITY QUESTIONNAIRE

Patient Name: _____ Acct #_____ Date of Birth: _____

Are these forms for: FMLA _____ Short term disability _____ Other _____

There is a **$25.00 charge per set of forms** for the completion of FMLA and/or disability forms.

This will need to be paid at the time you drop off your forms.

Please allow 7-10 days business days for completion of your form.

For a 24-hour turnaround there will be an additional fee of $10.00 per form.

1.) Please have **YOUR PORTION** of the forms completed. We cannot complete our portion without your signature. If this form is for someone other than the patient, please have the patient's name and relationship to the patient on the form for reference.

2.) When completed:

____Please fax form to number on paperwork or to _____ Attention: _____

____ Please send it by secure email to: _____

____Please call me to pick up.

3.) Please provide us with the following information to properly complete the form.

1. The date you anticipate beginning your disability _____
2. The date you anticipate returning to work* _____

We can only give the amount of time that is medically indicated. Vaginal Delivery 6 weeks, C/S 8 weeks

Physician: Abreu ___ Conway ___ Lindauer ___ Leeman ___ Maag ___ Miller ___

I authorize Northwest Obstetrics & Gynecology Associates, Inc. to release any or all my personal medical information to: _____ for the purpose of completing Disability /FMLA paperwork.

_____ _____

Signature of Patient **Date**

Internal use only: Number of forms _____ Pt paid $ _____ Rec'd by _____ Rev 03/2025