DISABILITY QUESTIONNAIRE

There will be a **$15.00 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.

Patient Name ____ Date of Birth __________________

FIRST……..Please make sure you have completed and signed **YOUR PORTION** of the FMLA/ disability form. We cannot complete our portion without your signature. If this form is for someone other than the patient, please make sure the patient's name and relationship to the patient is on the form for reference.

Are these forms for FMLA _________ or Short term disability ___________

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

SECOND…….Please tell us what you would like done with the form when completed.

____Please call me at ______________________ and I will pick it up.
____Please fax form to _____________________________ Attention: _______________________
____I will pick up the original form at my next visit
____Please mail form to the following name and address:

____

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THIRD…….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 __________________________________
3. A description of your current job responsibilities: ___________________________
   ____
4. Phone number(s) where you can be reached during the day ___________________

I authorize Northwest Obstetrics & Gynecology Associates, Inc. to release any or all of my personal medical information

to: ____ for the purpose of completing disability /FMLA paperwork.

____ ___________________
Signature of Patient Date

Internal use only

Pt paid $ _____________ by check # _________ cash cc _______ Rec'd by __________