West Suburban
Women's Health, Ltd.

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REQUEST FOR FMLA or SHORT TERM DISABILITY PAPERWORK COMPLETION

Date of Request: _____

Patient Name: _____ **Date of Birth:** _____

Type of Form:

- ❑ FMLA
- ❑ Short Term Disability

How does patient want paperwork sent?

_____ Fax: Number: _____

_____ Send in Mail: Street Address: _____

_____ Office Pick up

Does the patient want a copy of the letter? (*Please Circle*)? Yes No

Disability is due to:

- ❑ Pregnancy
- ❑ Surgical Procedure
    - o Physician performing surgery _____

Date(s) of Disability: _____

_____ I am aware that there is **a $20 processing fee** that is due at the time of this request. ***(please initial)***

_____ Fee collected ***(staff please initial)***

Other Information: _____

_____

_____

_____

Patient Instructions:

FMLA Paperwork – *Complete Sections I & II of the Federal Family and Medical Leave Act Form, return to staff member.*

Short Term Disability Paperwork - Complete as much of the form as possible, give to staff member for signature

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