Genesee County Drain Commissioner
Division of Water & Waste Services
G-4610 Beecher Road, Flint, MI 48532
810-732-7870
HR Fax 810-732-1934

RE: Planned Sick Leave

We are sorry to hear about your illness and hope that you recover quickly. Enclosed is the application for Short Term Disability and FMLA. You should complete your portion on both forms prior to your leave. The forms need to be returned to the HR office in person, faxed or mailed back to us prior to your leave. The doctor's statement is extremely important so if you can have your doctor complete it prior to your leave that would be great however many times the physician completes it after the start of the leave due to recovery issues etc. The physician can fax it directly to our office which will speed up the processing of your claim. The secure HR fax number is: 810-732-1934.

The short term disability plan has a 7 calendar day elimination period. As this has been deemed a Planned Leave you have the choice of covering your first five work days with personal or vacation. If you have not already given your supervisor a request for leave, complete the attached Request for Leave form with your choice of covering this time. Return it to our office as soon as possible.

You must provide to the HR office an original updated doctor's note if the doctor authorizes extension of your sick leave. The note must be provided to the HR office prior to the end of the approved sick leave date. The HR office will update the carrier.

You are required to provide a three working day return to work notice. You must produce a note from your Physician stating that you are released to work with no restrictions including a clear return to work date. It is strongly recommended that you notify your Physician that a three working day notice is a requirement of the Division. You will be required to visit the Division's doctors/clinic to obtain an occupational release for duty.

The day that you notify the Human Resource office in writing that you can return to work shall be considered day one of the three working day notice. Every effort will be made to get a timely appointment. If you contact us prior to what you anticipate your final physician appointment, we will try to schedule a clinic appointment that same day or the next day. REMINDER: you must provide a note from your Physician stating that you are released to work with no restrictions including a clear return to work date PRIOR TO YOUR CLINIC APPOINTMENT.

Please call Christine Simms or myself to make the clinic appointment prior to returning to work. If you have any questions I can be reached at (810) 732-7870 ext. 4128.

Sincerely,

Anne Figueroa

Anne Figueroa
HR Manager

Request for Leave

Name: _____ Department _____

Time Off: Date(s): _____, _____, _____, _____, _____

FROM _____ **TO**_____
(Time) **(Time)**

Charge To:

Personal Time: _____ **Hours**

Earned Vacation (Union Only): _____ **Hours**

Annual Leave (Vacation): _____ **Hours**

APPROVED FMLA _____ **Hours**

Holiday Hours _____ **Hours**

_____ _____
Employee's Signature Date of Request

_____ _____
Supervisor's Signature Date Approved:

Date: _____

Call In (PT): _____ **Hours**

_____
Supervisor Signature

EMPLOYEE'S SIGNATURE IS **NOT** REQUIRED ON THIS FORM WHEN PERSONAL TIME IS CALLED IN.

This is a qualified approval contingent on employee having earned enough of the requested time

GENESEE COUNTY
WWS
DRAIN COMMISSIONER

APPLICATION FOR FMLA LEAVE

Employee's name: _____

Location: _____ Department_____

Eligible employees are entitled under the Family and Medical Leave Act (FMLA) to up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons.

Submit this request form at least 30 days before the leave is to commence, when practicable. When submission of the request 30 days in advance is not practicable, submit the request as early as is practicable.

According to the Division's Family and Medical Leave (FMLA) policy, you are required to exhaust Vacation leave up to your annual allotment and Personal time above 40 hours before going on leave without pay for FMLA leave.

EMPLOYEE STATEMENT: I am requesting leave for the following reason:

☐ **For a serious health condition that makes me unable to perform my job**

(Medical certification must be provided 15 calendar days after date of application)

☐ **To care for a family member with a serious health condition**

(Medical certification must be provided 15 calendar days after date of application)

☐ **The birth of a child:** Expected Delivery Date_____

(Medical certification must be provided 15 calendar days after date of application)

☐ **The placement of a child for adoption or foster care** (documentation required)

☐ **To care for a spouse, son, daughter, parent, or next of kin to take up to 26 work weeks of leave to care for a member of the Armed Forces**

(Medical certification must be provided 15 calendar days after date of application)

DATE OF LEAVE REQUESTED:

☐ I request leave from _____to Expected Return Date_____

☐ I request intermittent leave according to the following schedule: _____

☐ I request reduced schedule leave according to the following schedule._____

The total number of days of leave that I request is: _____

Employee Signature _____Today's Date _____

Human Resource Signature _____ Date _____

Supervisor's Signature _____ Date _____

DISABILITY CLAIM FORM
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Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time).

CLAIM FRAUD STATEMENTS

For your protection, the laws of several states, including Alaska, Arizona, Arkansas, Delaware, Idaho, Indiana, Kentucky, Louisiana, Minnesota, New Hampshire, Ohio and Oklahoma, and others require the following statement to appear on this claim form:

Fraud Warning

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

Fraud Warning for California Residents

For your protection, California law requires the following to appear on this claim form:

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Fraud Warning for Colorado Residents

For your protection, Colorado law requires the following to appear on this claim form:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Fraud Notice for District of Columbia Residents

For your protection, the District of Columbia requires the following to appear on this claim form:

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Fraud Warning for Maine, Tennessee and Virginia Residents

For your protection, Maine, Tennessee and Virginia law requires the following to appear on this claim form:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Fraud Warning for Florida Residents

For your protection, Florida law requires the following to appear on this claim form:

Any person who knowingly and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Fraud Statement for New Jersey, New Mexico and Pennsylvania Residents

For your protection, New Jersey, New Mexico and Pennsylvania law requires the following to appear on this claim form:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Fraud Statement for New York Residents

For your protection, New York law requires the following to appear on this claim form:

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Fraud Statement for Puerto Rico Residents

For your protection, Puerto Rico law requires the following to appear on this claim form:

Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. If aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years; if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

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EMPLOYEE/INDIVIDUAL STATEMENT (PLEASE PRINT)

A. Information About You

Last Name | Suffix | First Name | MI

Date of Birth (mm/dd/yy) | Social Security Number | Gender ☐ Male ☐ Female

Home Address

City | State | Zip

Home Telephone Number | Cellular Telephone Number

The state in which you work | Preferred e-mail address (for confirmation purposes only)

Employer Name: Genesee County Water & Waste

Language Preference ☑ English ☐ Spanish

Please check all types of coverage you have with Unum.

☑ Short Term Disability ☐ Long Term Disability ☐ Individual Disability ☐ Life Insurance ☐ Voluntary Benefits Disability
☐ Voluntary Benefits Cancer/Critical Illness ☐ Voluntary Benefits Accident ☐ Voluntary Benefits MedSupport

Are you currently self-employed? ☐ Yes ☑ No | Do you work for another employer? ☐ Yes ☐ No

If yes, employer name | Telephone Number

B. Information About the Condition(s) Causing Your Disability

1. For **pregnancy**, answer the following questions then go to #4:

What is your expected delivery date? (mm/dd/yy)

Were there any complications causing you to stop work prior to your expected delivery date? ☐ Yes ☐ No | If yes, please explain:

Have you already delivered? ☐ Yes ☐ No | If yes, what type of delivery? ☐ Vaginal ☐ C-Section | If yes, date of delivery (mm/dd/yy):

2. For **illness**, answer the following questions then go to #4:

What is the name of your medical condition? | What were your first symptoms?

When did you first notice the symptoms? | Date you were first treated by a physician (mm/dd/yy)

3. For an **injury**, answer the following questions then go to #4:

What is the name of your medical condition?

Where and how did the injury occur?

Date the injury occurred (mm/dd/yy) | If related to a motor vehicle accident, was an accident report filed? ☐ Yes ☐ No | Date you were first treated by a physician (mm/dd/yy)

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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

4. For **all medical conditions**, answer the following questions:

What specific duties of your occupation are you unable to perform due to your medical condition?

Is your condition related to your occupation? ☐ Yes ☐ No | If yes, please explain how:

Have you filed a Workers' Compensation claim? ☐ Yes ☐ No

If no, do you intend to file a Workers' Compensation claim? ☐ Yes ☐ No | If no, please explain why you are not filing a Workers' Compensation claim.

C. Information About Your Disability

Date Last Worked (mm/dd/yy)	Number of Hours Worked on Date Last Worked	Date you were first unable to work due to this medical condition (mm/dd/yy)

D. Information About Physicians and Hospitals

Please provide the following information about all your current medical treatment providers (physicians, hospitals, physical therapists, etc.). If you are being treated by more than three, please share the following information for each provider on a separate sheet of paper and include it with this form.

1. Provider Name | Mailing Address | Telephone No. ( )
Specialty | City | State | Zip | Fax No.
Date of first visit for this condition (mm/dd/yy) | Date of next visit for this condition (mm/dd/yy)

2. Provider Name | Mailing Address | Telephone No. ( )
Specialty | City | State | Zip | Fax No.
Date of first visit for this condition (mm/dd/yy) | Date of next visit for this condition (mm/dd/yy)

3. Provider Name | Mailing Address | Telephone No. ( )
Specialty | City | State | Zip | Fax No.
Date of first visit for this condition (mm/dd/yy) | Date of next visit for this condition (mm/dd/yy)

Please list any hospital visits/admissions you have had in the last 12 months. If you have had more than two, provide the following information for each visit/admission on a separate sheet of paper and include it with this form.

1. Hospital/Facility Name | Address | Date of Visit/Admission (mm/dd/yy)
Procedure | City | State | Zip | Date of Discharge (mm/dd/yy)

2. Hospital/Facility Name | Address | Date of Visit/Admission (mm/dd/yy)
Procedure | City | State | Zip | Date of Discharge (mm/dd/yy)

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EMPLOYEE/INDIVIDUAL STATEMENT (Continued)

Employee/Individual's Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

E. Information About Other Disability Income. This information is important to ensure the accuracy of your disability benefit calculation.

You may be receiving income from other sources that could reduce your benefit from Unum. Please indicate what other income benefits you may be eligible to receive or are receiving as a result of your disability and complete the information requested.

Other Source of Income	May Be Eligible to Receive	Receiving
State Disability Plan (CA, HI, NJ, NY, PR, RI)	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Workers' Compensation	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Motor Vehicle Insurance	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Third Party Settlement/Income	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Social Security/Disability	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Social Security/Family	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Social Security/Retirement	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Unemployment	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Pension/Disability	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Pension/Retirement	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Canada Pension	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
Public Employee Retirement System	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown
State Teachers Retirement System	☐ Yes ☐ No ☐ Unknown	☐ Yes ☐ No ☐ Unknown

Other Short Term Disability Coverage ☐ Yes ☐ No If yes, please list the insurance company name.

F. Information About Your Return-to-Work

Have you returned to work? ☐ Yes ☐ No If yes, indicate date below.
Part Time (mm/dd/yy): Full Time (mm/dd/yy): Hours per week:

If you have not returned to work, when do you expect to return?
Part Time (mm/dd/yy): Full Time (mm/dd/yy): ☐ Unknown

G. Information About Income Tax Withholding. The following information will ensure your benefit is taxed appropriately according to Federal and State regulations.

TAX INFORMATION
If you do not know if you are covered under a fully-insured or self-funded plan, please contact your employer for assistance.

- **For Fully-Insured Plans –** If your request for benefits is approved, should Unum withhold Federal and/or State Income Taxes from your benefit checks?
  Federal Income Tax: ☐ Yes ☐ No If yes, how much should be withheld from each check? (whole dollar amount) $_____
  Minimum Withholding: $20/week for Short Term Disability and $88/month for Long Term Disability.
  State Income Tax: ☐ Yes ☐ No If yes, how much should be withheld from each check? (whole dollar amount) $_____
- **For Self-Funded Plans –** Attach a copy of your completed W-4 for accurate calculation of Federal and State income taxes. **Note:** If not provided, we are required by law to withhold 25% of your benefit for Federal Income Tax and the maximum withholding amount for State Income Tax.

H. Signature of Employee/Individual

I have read and understand the fraud notices listed on page 2 of this form. I also acknowledge that should my claim be overpaid for any reason it is my obligation to repay any such overpayment. The above statements are true and complete to the best of my knowledge and belief. **(Your signature is required for benefit consideration.)**

X _____ **Signature** _____ **Date**

Reminder: Please sign and date the Authorization (last page of this claim form).

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EMPLOYEE/INDIVIDUAL AUTHORIZATION – FOR EMPLOYEE TO COMPLETE

NOTE: This authorization is designed to comply with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. You are not required to sign the authorization, but if you do not, Unum may not be able to evaluate or administer your claim(s). Please sign and return this authorization to The Benefits Center noted above.

Authorization

I authorize any health care provider including, but not limited to, any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service; health plan; rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; producer; the Medical Information Bureau; GENEX Services, Inc.; the Association of Life Insurance Companies, which operates the Health Claims Index and the Disability Income Record System; government organization; professional licensing body; and employer that has information about my health, financial or credit history, professional license, earnings, employment history, or other insurance claims and benefits, including Social Security benefits, to disclose any and all of this information to persons who administer claims for Unum Group, its insurance subsidiaries* and duly authorized representatives ("Unum"), and, where applicable, to persons or entities that may assist me with or provide services related to my claim(s) for Social Security or other government-sponsored benefits. Information about my health may relate to any disorder of the immune system including, but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

I understand that any information Unum obtains pursuant to this authorization will be used to evaluate and administer my claim(s) for benefits, including any assistance in my return to work. I further understand that the information is subject to redisclosure and might not be protected by certain federal regulations governing the privacy of health information.

This authorization is valid for two (2) years from the date below, or the duration of my claim, whichever is shorter. A photographic or electronic copy of this authorization is as valid as the original. I understand I am entitled to receive a copy of this authorization.

I may revoke this authorization in writing at any time except to the extent Unum has relied on the authorization prior to notice of revocation or has a legal right to contest a claim under the policy or the policy itself. I understand if I revoke this authorization, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). I may revoke this authorization by sending written notice to the address above.

I understand if I do not sign this authorization or if I alter its content in any way, Unum may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

_____ _____
(Employee/Individual Signature) (Date Signed)

_____ _____
(Print Name) (Social Security Number)

I signed on behalf of the claimant as _____(indicate relationship). If Power of Attorney Designee, Guardian, or Conservator, please attach a copy of the document granting authority.

* This authorization is valid for the following Unum insurance subsidiaries: Unum Life Insurance Company of America, Provident Life and Accident Insurance Company, The Paul Revere Life Insurance Company.

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ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

PART I: TO BE COMPLETED BY PATIENT

Name of Patient (Last Name, Suffix, First Name, MI) | Social Security Number

Date of Birth (mm/dd/yy) | Home Telephone Number | Employer Telephone Number

Employer Name

PART II: TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Instructions: Please complete, sign and date this statement. The purpose of this report is to assist us in making a disability determination. If this claim is related to a normal pregnancy, complete Section A. Otherwise, please complete all applicable sections of this form and provide copies of supporting reports, such as office notes, medical records, consultations and/or testing. In all situations, please complete the signature block at the bottom of this form.

A. Complete this section for normal pregnancy, then go to section C

Expected Delivery Date (mm/dd/yy):	Actual Delivery Date (mm/dd/yy):	Delivery Type: ☐ Vaginal ☐ C-Section	Date of first visit for this pregnancy (mm/dd/yy):	Date Hospitalized (mm/dd/yy):

Did you advise your patient to stop working? ☐ Yes ☐ No If yes, on what date (mm/dd/yy)?

Diagnosis:	ICD9 Diagnosis Code:	Height:	Weight:	Blood Pressure: As of date (mm/dd/yy):

B. Complete this section for all conditions except normal pregnancy

Patient Information

Height:	Weight:	Date of first visit for this current condition(s) (mm/dd/yy):	Did you advise your patient to stop working? ☐ Yes ☐ No If yes, on what date (mm/dd/yy)?

Has the patient been treated for the same/similar condition in the past? ☐ Yes ☐ No ☐ Unknown

If yes, please provide treatment dates (mm/dd/yy): From Through

Is the patient's condition due to injury or sickness involving the patient's employment? ☐ Yes ☐ No ☐ Unknown

Diagnosis

What is the primary diagnosis preventing the patient from working?

Please include primary ICD-9 or DSM IV Multi-Axial diagnoses codes	ICD9:			
DSMIV: I	II	III	IV	V

What are the other conditions that prevent the patient from working? ☐ NA

Secondary ICD-9s:	Diagnosis:
Secondary ICD-9s:	Diagnosis:

Are there any cognitive deficits or psychiatric conditions that impact function? ☐ Yes ☐ No
If yes, please provide restrictions and limitations:

Date of last examination (mm/dd/yy):	Date of next examination (mm/dd/yy):

What symptoms is your patient reporting about his/her condition?

What diagnostic or clinical findings support your diagnosis?

What diagnostic or clinical findings support your patient's work restrictions and limitations?

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name (Last Name, Suffix, First Name, MI) | Date of Birth (mm/dd/yy)

Treatment

What is your treatment plan?

When do you expect the patient to improve to return to work?

Medications (Please attach medication log)

Has the patient been hospitalized? ☐ Yes ☐ No If yes, date hospitalized (mm/dd/yy): through (mm/dd/yy):

Facility Name

Address

City | State | Zip

Was surgery performed? ☐ Yes ☐ No | If yes, what procedure was performed? | Date Surgery Performed (mm/dd/yy):

Is the patient still under your care? ☐ Yes ☐ No | If no, final date of treatment:

Other Providers: Are you aware of or have you referred your patient to other treating providers? If yes, please provide complete name, contact information and specialty of any other treating physicians or hospitals.

Name	Specialty	Address	Phone #

Functional Capacity This is your estimate of your patient's functional capacity based on your knowledge of the patient. This information is important to assess your patient's eligibility for disability benefits.

Patient's ability to: *(Please check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Walk	☐	☐	☐	☐

Patient's ability to perform: *(Please Check)*

	Never 0%		Occasionally 1-33%		Frequently 34-66%		Continuously 67-100%	
	R	L	R	L	R	L	R	L
Fine Finger movements	☐	☐	☐	☐	☐	☐	☐	☐
Hand/eye coordinated movements	☐	☐	☐	☐	☐	☐	☐	☐
Pushing/Pulling	☐	☐	☐	☐	☐	☐	☐	☐

Dominant Hand ☐ Right ☐ Left

Patient's ability to: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Climb	☐	☐	☐	☐
Twist/bend/stoop	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Operate heavy machinery	☐	☐	☐	☐

Patient's ability to lift/carry: *(Please Check)*

	Never 0%	Occasionally 1-33%	Frequently 34-66%	Continuously 67-100%
Up to 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient's Name (Last Name, First Name, MI, Suffix) | Date of Birth (mm/dd/yy)

Return to Work Assessment

Have you advised the patient to return to work? ☐ Yes ☐ No | If yes, expected return to work date (mm/dd/yy): ☐ Full Time ☐ Part Time | Hours per day

If yes, please indicate any ongoing restrictions and limitations in the space provided below.
If no, please indicate the restrictions and limitations that prevent the patient from returning to work in the space provided below.

CURRENT RESTRICTIONS (activities patient should not do)

CURRENT LIMITATIONS (activities patient cannot do)

Do you support your patient's return to work within the restrictions and limitations you provided? ☐ Yes ☐ No | If yes, as of (mm/dd/yy):

If no, when do you expect improvement in the patient's functional capacity?

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Attending Physician portions of the claim form.

C. Signature of Attending Physician

The above statements are true and complete to the best of my knowledge and belief.

Physician Name (Last Name, First Name, MI, Suffix) Please Print

Medical Specialty | Degree

Address

City | State | Zip

Telephone Number | Fax Number | Physician's Tax ID Number:

Are you related to this patient? ☐ Yes ☐ No
If yes, what is the relationship?

Signature of Physician | **Date**

X