IF YOU NEED A FMLA FORM
PLEASE COMPLETE ALL OF THE FOLLOWING:

Patient Name:_____DOB:_____

Specific Dates needed (please list):_____

Intermittent leave needed: **Y N** How many days or hours per month:_____

_____

Reason needing time off (surgery, therapy, etc.):_____

Person form is for:_____Relationship to child:_____

Phone # to be reached at if any questions:_____

Check all that apply:

_____ I will pick up form.

_____Mail form to Attn:_____

Address:_____

Fax Form To: Name of Company:_____

Attn:_____Fax #:_____

Please allow 4 – 5 days for completion. Each case must be reviewed by a physician for necessity and is not a guarantee form can be completed. There is a $10 fee per child per request due at the time of the request. If form cannot be completed a full refund will be issued to you.

Print Name of Person dropping off form:_____Date:_____

Signature Parent/Legal Guardian:_____

THIS FORM MUST BE FULLY COMPLETED TO PROCESS YOUR REQUEST