Seattle OB/GYN Group
Official FMLA/Pregnancy Disability Form

Patient Name: ______________________________
Birthdate: ____________
Estimated Date of Confinement: _____________ Expected ___ Actual ___

Diagnosis: Pregnancy
Complications, if any: ___________

Expected Recovery:
- 6 weeks if vaginal delivery
- 8 weeks if Cesarean delivery
- Full return to usual duties after FMLA unless otherwise noted

Tax ID: 91-1665536

Hospital: Swedish Medical Center, 747 Broadway, Seattle, WA 98122

If patient requires an additional form, there will be a pre-paid fee of $25.

Physician Signature: _____________________________
Date: __________