Moreland OB/GYN Associates, S.C.
Family Medical Leave (FMLA) and Disability Forms

Name: _____ Date of Birth: _____

Is this paperwork for the patient or spouse: _____

Please make sure the patient information section of your medical leave forms have been completed and signed. We need your signature in order to release information.

Notice: It is the practice of Moreland OB/GYN to complete paperwork for the time off that is medically necessary for each incident, unless discussed with the physician.

FOR PREGNANCY:
(If applicable)

Due Date: _____
First day of medical leave: _____
If prior to Due Date reason: _____
Anticipated amount of time off: _____
Scheduled Cesarean Section date: _____
Date you anticipate to return to work:_____

FOR SURGERY:
(If applicable)

Date of Surgery:_____
Is your surgery a day surgery or major surgery: _____
First day of medical Leave(if different):_____
Anticipated amount of time off: _____
Date you anticipate to return to work:_____

Submitting Paperwork:
(Check all boxes that apply)
Please write in any phone numbers or addresses.

□ **Mail form to:**
Attention: _____
Address: _____
City:_____ State:_____ Zip: _____

□ **Call when form is completed**:
Phone number:_____

□ **Fax form to:**
Fax number: _____

Would you like a copy to keep for your own records: □ Yes □ No

----------Employee use only----------

Patient Label:

Employee initials:_____
Date:

6/2011

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Please understand that Moreland OB/GYN Associates, S.C. will provide the information within 7-10 business days from the original request. If you have any questions please feel free to contact our office.

----------Employee use only----------

Patient Label:

Employee initials:_____

Date:

6/2011