Dallas Family Medical & Aesthetics
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**FMLA / DISABILITY FORM COMPLETION REQUEST**

Patient Name: _____ DOB_____Today's Date_____

Reason for Request: _____

_____

_____

Specific Reasons: _____

_____

_____

Amount of time requested ____days ____ months ____years | Start Date _____ End Date _____

Date requested for forms to be completed by: _____

How you would like forms returned: EMAIL | FAXED TO PROVIDED NUMBER | PICK UP AT OUR OFFICE

Fax No. _____ Email _____

• There will be a fee of $50.00 for completion of forms that need to be paid at date requested. If there are any changes that need to be made from information given above, please be aware that there will be an additional $50.00 charge, this includes extending time if needed than originally requested.

• FMLA/Disability forms are completed for those accounts in good standing. Outstanding balances must be paid to prior to forms being filled out.

• Blank forms will not be accepted. Personal information must be completed BEFORE forms are given to provider.

• FMLA/Disability will be completed in 1-2 business days, not at the same time as visit.

• In order to continue with FMLA/Disability you must keep ALL scheduled appointments. In the case of an emergency or missed appointment an appointment must be rescheduled.

• Further requests for extended time requested will require an appointment before approving extended FMLA/Disability.

• Please be aware that your employer/insurance are ultimately who make the decision about the approval or submitted request.

_____ _____
Print Name of Patient or Legal Guardian Date

_____ _____
Signature of Patient or Legal Guardian Date