OAKLAND • MACOMB
OBSTETRICS & GYNECOLOGY, P.C.

FMLA/Disability Insurance Forms Request

****Forms will not be completed on a "while you wait" basis****

Date _____

Patient Name _____

Date of Birth _____

Phone Number _____

Family Members Name _____

Reason for Forms

- ☐ Surgery/Recovery
- ☐ Pregnancy/Delivery
- ☐ Intermittent leave for prenatal care or illness
- ☐ Other

For: GYN SURGERY ☐ DELIVERY ☐ METHOD (circle one) SVD/C-SECTION

Were you admitted to the hospital? ☐ Yes ☐ No

If YES – What are the dates you were admitted and discharged? _____

Leave Information:

Last Day Worked: _____ Return to Work: _____ DUE Date: _____

Actual Date of Delivery: _____ ☐ Vaginal ☐ C-Section

Family Member Leave: Start Date: _____ Estimated Weeks Needed: _____

If you want form faxed, please provide desired fax number: _____

Form fee is $30 per set of forms and payment is due when you drop off the forms. You are responsible for the fee if your disability company faxes form to the office on your behalf.

Please allow 10 business days for completion of forms.

Completed **faxed** forms will be mailed to your home, these are your copies to keep

FOR OFFICE USE: # of Sets of Forms: _____Paid: $_____Date: _____Initials: _____