OAKLAND MACOMB

FMLA/Disability Insurance Forms Request

OB/GYN

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

Date _____

Patient Name _____

Family Members Name _____

Date of Birth _____

Phone # _____

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? _____

DATES you want on forms:

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

Actual Date of Delivery: _____ Vaginal OR C-Section

Family Members: 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 forms 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: _____