DUNWOODY OBSTETRICS & GYNECOLOGY, PC

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Disability Form Request

Patient Name:_____ Date of Birth:_____

Name of Requestor:_____Phone Number:_____

Requesting Company:_____ Date of Request:_____

Type of Form: ____FMLA ____STD ____RTW _____Other (please specify)

Date Form Needed:_____

How Should This Form be submitted? _____Fax _____Patient Pick Up ____Mail

Please provide the person's name and or department, fax number, or mailing address for submission here:

_____

_____

_____

When will you (did you) stop working?_____

When will you return (did you) to work?_____

What is your understanding of why you will be unable to work?_____

_____

_____

_____

_____

PLEASE NOTE THERE IS A $25 FEE FOR EACH FORM REQUEST *
****FORMS ARE COMPLETED WITHIN 10 BUSINESS DAYS****
****FORM COMPLETION BEGINS ONCE THE FORM FEE IS RECEIVED****
****PLEASE FAX OR E-MAIL COMPLETED FORMS TO 770-828-0637 OR DOBG-GMBL@AWHG.ORG****

FOR OFFICE USE ONLY

Date form received:_____ date payment received:_____
Date patient notified of completion:_____ Date form Sent:_____
Form completed by whom:_____