WOMEN LIVING WELL
OBSTETRICS & GYNECOLOGY

FMLA/SHORT-TERM DISABILITY FORMS

PATIENT NAME: _____

PATIENT DATE OF BIRTH: _____

ARE SPOUSE/SUPPORT PERSON FMLA FORMS INCLUDED? **YES** **NO**

IF YES, PLEASE PROVIDE SPOUSE/SUPPPORT PERSON'S NAME AND DATE OF BIRTH:
_____

PRIMARY OBGYN PROVIDER:	JESSICA APEL	KIRSTEN SMITH
PLEASE CIRCLE WHICH APPLIES:	FMLA	SHORT TERM DISABILITY

PLEASE CIRCLE WHICH APPLIES: INTERMITTENT LEAVE DURNING PREGNANCY
POSTPARTUM
GYN SURGERY
OTHER _____

DATE RANGE FOR FMLA OR SHORT-TERM DISABILITY
PATIENT _____

DATE RANGE FOR FMLA OR SHORT-TERM DISABILITY
SPOUSE OR SUPPORT PERSON (if applicable) _____

*If taking intermittent leave **during** pregnancy, please **specify qualifying reason and date ranges***
_____
_____
_____

ARE YOU SCHEDULED FOR A C SECTION OR GYN SURGERY? **YES** **NO**
If yes, please answer below

Name of procedure: _____

Scheduled date: _____

***Patient acknowledgement**- Completed forms are either faxed or picked up by patient/spouse/support person. We cannot email completed forms. Allow **7-10 business days** for processing and paperwork completion. There is a $20 administrative fee for each form completed. Please **circle** below one method of paper retrieval.*
Fax #_____ **Attention**: _____ **Mail To**: _____ **Pick Up? Y N**

PATIENT SIGNATURE _____

Lifeline Medical Associates