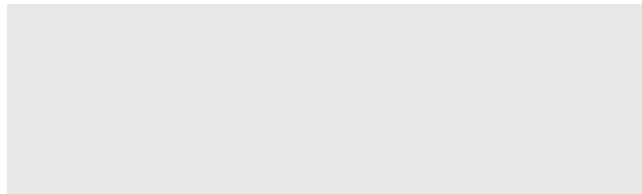
THE DEPARTMENT *of* OBSTETRICS AND GYNECOLOGY



FAMILY MEDICAL LEAVE ACT / DISABILITY PATIENT QUESTIONNAIRE

We are happy perform this service free of charge and we thank you for your patience as we have a 5-7 business day turnaround time for forms to be completed once they are received in our office. Please note that if additional information is needed from your provider, it could take longer for your form(s) to be processed.

Please answer all questions completely and return form and paperwork to the receptionist when you are done.

Date:__________ Provider:__________ Medical Record Number:__________

Name:__________ Birth date:__________ Daytime phone:__________

Obstetrical patients

Due date:__________ Do you plan to work until you deliver: Yes / No Are you off work now? Yes / No

First day off:__________ Please list any complications:__________

Were you hospitalized: Yes / No If yes, dates:__________ Hospital:__________

Delivery date:__________ Type of delivery: Vaginal or C/section Hospital:__________

Surgical patients

Date of surgery:__________ First day off work:__________ First day back to work:__________

List any complications:__________

Leave needed for a family member

Family member's name:__________ Relationship to patient:__________

Reason for leave:__________ Days off needed:__________

Once paperwork is completed

☐ Call patient when complete ☐ Patient to pick up form on:__________(date)

Mail form to:__________

Fax form to:__________

Name of business Attention to

Fax number:__________