FMLA and Disability Forms – Patient Acknowledgement Form

WE ONLY ACCEPT ORIGINAL FORMS. WE DO NOT ACCEPT FORMS BY FAX.

WE WILL NOT ACCEPT FORMS FROM PATIENTS UNTIL ALL PATIENT AND/OR EMPLOYEE SECTIONS OF THE FORMS ARE COMPLETE AND THE APPROPRIATE MEDICAL RECORD RELEASE HAS BEEN SIGNED.

IT MAY TAKE UP TO 14 BUSINESS DAYS TO COMPLETE FMLA AND/OR DISABILITY FORMS.

THERE IS A **$25.00** FEE TO COMPLETE **EACH** SET OF FORMS, AND THE FORMS WILL NOT BE RELEASED UNTIL THIS FEE IS PAID. (*THERE IS A SEPARATE **$25.00** FEE FOR EACH SUBSEQUENT SET OF FORMS.)*

The Family and Medical Leave Act (FMLA) provides an entitlement of up to 12 weeks of job-protected, unpaid leave during any 12-month period to eligible, covered employees for the following reasons: 1) Birth and care of the eligible employee's child, placement for adoption or foster care of a child with the employee; 2) care of an immediate family member (spouse, child, parent) who has a serious health condition; or 3) care of the employee's own serous health condition. (Visit the US Department of Labor website for more information about FMLA).

_____ (Initial) ***FMLA forms may be completed after your due date is established or your surgery is scheduled.***

Disability insurance pays benefits to employees who are not working due to non-job-related accidents or illnesses. Many patients have disability insurance through their employers, or that they have purchased on their own.

____ (Initial) ***Disability forms will not be completed until you are actually disabled due to birth of a child, surgery, illness or complication of pregnancy that requires the patient cease working.***

We do not fax completed paperwork. You will be notified by our office once your original forms have been completed and are ready for pick up.

Please provide the information and dates below:

Reason for FMLA and/or Disability _____

Estimated Due Date _____ Delivery Date _____ Surgery Date _____

Dates missed work _____ Return to work date _____

Dates hospitalized _____ Hospital _____

I acknowledge that I have read and understand the above Caring Center for Women FMLA/Disability Form Policy.

Patient Name (Printed) _____ Date of birth: _____

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Office use: (Initial and date) Fee(s) paid: FMLA forms _____ Disability forms _____