WOMEN PHYSICIANS IN OBGYN, INC.
FMLA/DISABILITY ACKNOWLEDGEMENT

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There is a $25 charge for the completion of the 1st set of paperwork. Additional paperwork for the same medical incident is $15 for the 2nd set, and $10 for the 3rd set. Your paperwork will be completed within 5 business days. Payment is required prior to processing.

Patient Name: _____ DOB: _____

If paperwork is for spouse/caretaker, please list their name: _____

Address: _____ City_____ Zip_____

Home Phone: _____ Cell: _____Work: _____

Beginning Date of Your Disability: _____

Reason for FMLA/Disability Leave: _____

_____

If maternity related, please list expected due date or planned cesarean section date: _____

Please indicate how you would like us to submit your paperwork upon completion:

_____Fax number: _____

_____Email: _____

_____Returned to you (NOT submitted)

I authorize WPIOBGYN to release information pertaining to FMLA/Disability to the appropriate company/employer.

Signature: _____
Date: _____

**********OFFICE USE ONLY**********

Pmt Rcvd_____ Amount_____ Method_____ Acct#_____ Emp Initials_____