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FMLA/ SHORT TERM DISABILITY/ MISC

PATIENT NAME: _____

DOB: _____

SPOUSE NAME: _____

DOB: _____

PREGNANCY / SURGERY

PREGNANCY EDD: _____

REQUESTED AMOUNT OF TIME OFF: _____

SURGERY DATE: _____

REQUESTED AMOUNT OF TIME OFF: _____

PROVIDER: _____

Received: _____

Paid: _____

PICK-UP/ FAX

FAX #: _____

\$25- Fee: Due when submitting paperwork. Please note any additional changes for FMLA paperwork will be a charge of \$25 (per change/ add-on).

Please allow 7-10 business days for the completion of paperwork