FMLA / DISABILITY PAPERWORK COVER SHEET

(a separate cover sheet must be completed for each set of FMLA/disability paperwork)

PATIENT NAME PRINTED: ____________________________DATE OF BIRTH: ____________________

PHYSICIAN: ____

FORMS BEING COMPLETED FOR: ☐SELF ☐SPOUSE ☐OTHER: ______________________

****PLEASE ALLOW 10 BUSINESS DAYS FOR COMPLETION OF FORMS****

THANK YOU!!

DATES YOU ARE REQUESTING OFF:

Continuous dates (if required): FROM: ______________ TO: ______________

Intermittent / Hours / Dates (if required): ______, ______, ______, ______, ______

Date you plan to return to work: ____

REASON:

Date of delivery: __________ Type of Delivery: _______Vaginal _______ Cesarean

Which Hospital did you deliver at? ____

Other surgical procedure: _________________________ Hospital: _________________

Date of hospital admission: _____________Date of hospital discharge: _______________

Last date worked: ____

HOW WOULD YOU LIKE US TO HANDLE YOUR COMPLETED FORMS?

Pick up: __________ Phone # to call when completed: _______________________

Fax to: Fax # __________________________ Attn: ______________________________

Mail to this address: ____

____

____

Other: ____

____

- -

SECTION BELOW FOR OFFICE USE ONLY: **DATE RECEIVED:** __________

PATIENT NAME: ____________________________________**ACCT #**______________________ **INITIALS:** ______

PAID $________________ **METHOD:** ☐**CASH** ☐**CK#**________ ☐**CREDIT/DEBIT** ☐**CREDIT ON ACCT**

NURSE COMPLETING FORMS: __________________________ **DATE COMPLETED:** ____________________

College Park Family Care Center
Midwest PHYSICIANS®

Medical Record Release Authorization

(For Use With Form Completion Request Only)

Patient Name _____Maiden/Previous Name_____

Date of Birth_____ Home Phone_____ Cell/Work_____

Address _____ City/State/Zip_____

Email Address: _____

A) I authorize the release of records FROM:

COLLEGE PARK FAMILY CARE CENTER

Provider:_____

B) To be released as required and outlined in the form submitted with this signed authorization, specifically to the following treatment and date/ range:_____

_____

_____

_____

_____

C) For the purpose of:

____Disability/FMLA

____Insurance

____Work Comp

____Other Explain:_____

I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I have read the information provided on this realease form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)

The authorization will expire one year from the date above unless I specify an expiration date: _____

(Expiration date of authorization)

Office staff: scan forms to monthly file. Do not send to CMR for processing.