Please inform patient and/or spouse that completion takes 5-7 business days. Patient will receive phone call when request has been processed and completed.

Date: _____/_____/_____

I authorize Eastside Gynecology & Obstetrics, PC to communicate with all third party disability insurance companies/employers regarding my disability.

Patient Signature: _____

Patient Name: _____ Date of Birth: _____
(please print clearly)

Patient Phone Number: (_____) _____-_____

Physician: _____

Please circle the appropriate request for the patient:

AFLAC Intermittent FMLA FMLA Spousal FMLA

☐ **PREGNANCY:**

Due Date? _____ Last day expected to work? _____

Return to work date? _____ *6 wks vag. delivery / 8 wks C-section

Please list all complications if requesting more than 2 weeks release prior to due date:

_____

_____

☐ **SURGERY:**

Type of surgery? _____
Scheduled surgery date? _____
Last date expected to work? _____ Return to work date? _____

Patient preference for delivery of disability release: (please circle one)
Pick up in office Mail (envelope attached) Fax (____) _____-_____

☐ **Health Maintenance Form**

☐ **Disability**

Paid ☐
Initials_____
Date _____

Payment Type
Credit ☐
Cash ☐
Check ☐