



DISABILITY FORM REQUEST
Obstetrics & Gynecology

Because of the excessive paper work that some companies (employers and insurance companies) are demanding, we charge \$25.00 for the completion of each disability form. You have a choice of obtaining a letter stating your condition and dates of disability at no charge or paying the \$25.00 charge to have your form completed. We require 48 hours to complete this form.

Please answer the following questions in order to allow us to complete your form:

Patient Name: _____

Social Security Number _____ Date of Birth _____

Which option are you requesting at this time?

Letter with all pertinent information (at no charge) Fill out your complete form (\$25.00 charge)

Reason for disability:

Maternity Leave Pregnancy Complication Surgery Other _____

MATERNITY LEAVE (Usually a period of 6 weeks for vaginal & Cesarean Delivery)

Date of last menstrual period: _____ Estimated delivery date: _____

Are there any complications requiring you to stop working before your delivery date? Yes No

If yes, please explain _____

Last day at work _____ Date returning to work _____

SURGERY

Type of surgery _____ Date of surgery _____

Last day at work _____ Date returning to work _____

OTHER

Reason for disability _____

Last day at work _____ Date returning to work _____

IF HOSPITALIZED:

Name of Hospital _____

Admit Date _____ Discharge Date _____

Mail completed form to: _____

Patient will pick up form on _____

"I authorize The Women's Health Group, its representatives and agents, to release all information requested in my disability form to the company named above. I understand and agree to pay the \$25.00 charge for form completion."

Patient Signature

Date