



**FMLA FORM REQUEST**  
Obstetrics & Gynecology

Because of the excessive paper work that some companies (employers & insurance companies) are demanding, we charge \$25.00 for the completion of each FMLA form. We require 48 hours to complete this form. Please bring completed form with your forms and payment to the office.

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

Reason for FMLA:

- Appointments / Testing
- Pregnancy Complication
- Maternity Leave
- 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 \_\_\_\_\_

**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 FMLA form to the above named company. I understand and agree to pay the \$25.00 charge for form completion."

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print your name

\_\_\_\_\_  
Date of Birth