The Ear, Nose, Throat & Plastic Surgery Associates

FMLA/Disability Forms

To Our Patient: ***In order to processs your request for FMLA/Disability paperwork, please complete this form.***

Please be sure you have completed and signed any patient portions of the FMLA/Disability forms.

Your Name: _____

Address: _____

_____

Date of Birth: _____

Contact Phone Number: _____

Name of Your Physician: _____

Reason for Completing FMLA Form: _____

Date Requested For Your Leave to Begin: _____

Anticipated Return to Work Date: _____

Additional information that will help us complete your forms:

_____

_____

Would you like the original forms mailed to you? _____ Yes _____ No

If No, Send Forms To: _____

_____

_____

Please note: Disability forms require a signed authorization to release information.

Please allow up to 10 days to process this FMLA form.

10/10/08