



FMLA & DISABILITY QUESTIONNAIRE

Today's Date: _____

First and Last Name: _____

If Not Patient, Patient Name: _____

Date of Birth: _____

Expected Date of Delivery (If Applicable): _____

Phone Number: _____

Reason for Leave: _____

Starting Date of Leave: _____

Approximate Return to Work Date: _____

List of Any Current Complications: _____

Are You Currently on Bed Rest: Yes No

If so, Why?: _____

Your Provider: Dr. Nwachuku; Dr. Diaz; Anne Jones, CNM

Would you like Forms Returned Via: Fax Pick Up from Office

If by Fax: Fax #: _____

- ❖ Some FMLA/Disability requests may require signatures or personal information. Please be sure to complete those fields, and include with the necessary documentation to be filled out by the provider.
- ❖ Please allow up to 10 business days for completion of forms.