Cassie HEALTH CENTER

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: (Circle One)

Dr. Diaz Denise Galaz, CNP Anne Jones, CNM Candace Laramore, CNP

Randi Murphy, DNP Dr. Nwachuku Aujenae Ore, CNM Dr. Rogers

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.