Mercy Clinic Women's Health
FMLA/Disability Paperwork

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Your paperwork will be completed within 10 BUSINESS DAYS of receiving it.

Patient Name: ____________________________________ Date of Birth: ______________________

If Form is For Spouse, Their Name and Date of Birth: ____

Address: ____ City: ___________________ Zip: __________

Home Phone: ________________________________ Cell Phone: _____________________________

May we leave a message with questions or to let you know when the forms are completed? YES / NO

Beginning date of leave request: ____

Reason for leave being requested: ____

Fax Number to send FMLA/Disability Paperwork to: ____

IF RELATED TO PREGNANCY/DELIVERY/POST PARTUM CARE:

Type of delivery: Vaginal / Cesarean Section / uncertain

If you have not delivered yet, what is your estimated due date: ____________________________________

How long are you requesting leave for? (6weeks, 8weeks, 12 weeks, etc): _________________________

Requested Return to Work Date: ____

IF RELATED TO SURGERY:

Date of Surgery: ____

How long are you requesting leave for? (6weeks, 8weeks, 12 weeks, etc): _________________________

Requested Return to Work Date: ____

Comments: ____

I AUTHORIAZE MERCY CLINIC WOMEN'S HEALTH TO RELEASE MY INFORMATION PERTAINING TO MY DISABILITY/PREGNANCY/FMLA TO THE DISABILITY COMPANY OR MY EMPLOYER.

Signature: ____ Date: _____________________________