



FMLA Form Completion Request

We want to provide you with an accurate FMLA form. Please provide clear and accurate information. After completion, please leave this form along with the FMLA forms required by your employer with our front desk and your physician will complete as soon as possible.

Patient Name: _____ Date of Birth: _____

Person completing form: _____ Today's Date _____

- 1. Is the form being completed due to illness on the part of the employee or due to illness of a family member? Please check one of the following: [] Self [] Spouse [] Child [] Parent
2. Is the Family Medical Leave you are requesting: [] Intermittent [] Continuous [] Worker's Comp Family Leave
3. What is your/family member's condition or diagnosis?
4. When did this condition start?
5. Are there other physicians involved in your/family member's care? If yes, please list:
6. Have you been absent from work due to this condition? If so, please provide dates.
7. When do you anticipate returning to work?
8. Will there be additional treatments? Who will be providing these?
9. If this leave is being requested for the care of a family member, do they need assistance for basic medical or personal needs, for transportation or safety?
10. If the answer to number 9 is no, is your presence needed for the family members psychological comfort or assistance in recovery?
11. Have you completed all sections of the form to be completed by the employee?

For Office Use Only: Form Fee: [] Paid [] Not Paid Collected by: _____