

Today's date: _____

MEDICAL FORMS

Please answer the following questions, which will assist in the accurate completion of your insurance, disability, and/or family medical leave forms.

Patient name: _____

Form is for (circle one): Patient Spouse Other: _____

1. Please complete and sign your portion of the form (if required on your form).
2. When will be or was your first day off work? _____
3. When do you anticipate returning to work? _____
(Please note that you must be aware of your company's policy for returning to work.)

Keep in mind, under normal circumstances, you will be under your doctor's care:

Vaginal delivery: 6 weeks

C-section delivery: 8 weeks (6 weeks only for some disability carriers)

Post-operative: 1 day to 6 weeks (depending on surgical procedures)

4. If this form is only for decreasing work hours temporarily, what are the hours you will be working and the duration of the reduced hours? _____

5. How should we handle this form upon completion of the physician information:
 - a. _____ Mail it to your home address.
 - b. _____ Mail or fax it back to the company for whom the form is being completed.
Company: _____ Fax #: _____
 - c. _____ Leave it at the front desk and it will be picked up at your next office visit.
 - d. _____ Notify you when the form is completed and you will pick it up from the front desk. If this option is chosen, please list the phone number where we can notify you when the form is ready to be picked up. Phone #: _____
6. There is a \$25.00 fee for completing each set of forms. This fee is due prior to the completion of the forms. You will pay: ___ By cash or check ___ By Visa, Mastercard, or Discover

I give my consent for Consultants in Women's Healthcare to release necessary medical information to the employer and/or insurance company requesting the information.

Signature _____ Date: _____