REQUEST FOR FMLA/SHORT TERM DISABILITY FORM COMPLETION

Today's Date:_____ Patient Name:_____

Date of Birth:_____ Phone Number:_____ SSN:_____

Reason for Request:

- ☐ History of Skin Cancer
- ☐ Surgery
- ☐ Other (Please Explain)_____

_____

Dates Requested for Leave: _____ to _____

Completed Paperwork will be:

- ☐ Picked up by:_____ At: _____
- ☐ Mailed to: _____
- ☐ Faxed to:_____ Attn:_____

Additional Information:_____

Please allow one week for forms to be processed. There is a $31.00 fee per form

Please note payment is required before forms are completed. All sections of the form that are required to be completed by the patient must be filled out prior to our office receiving the form. Please do not write in any section of the form marked for the physician to complete.

GATEWAY MEDICAL BUILDING, SUITE 130 • 7450 KESSLER ST. • MERRIAM, KS 66204
CREEKWOOD MEDICAL BUILDING, SUITE 201 • 5330 N. OAK TRAFFICWAY • KANSAS CITY, MO 64118
SEAPORT COMPLEX/MARINER BUILDING • 124 WESTWOODS DRIVE • LIBERTY, MO 64068
8490 COLLEGE BOULEVARD • OVERLAND PARK, KS 66210
MAIN (816) 454-0666 • FAX (816) 559-7118 • WWW.MIDWESTMEDICALSPECIALISTS.COM

For Office Use Only

Payment:	Approved:	Completed By:	Completion Date: