Midwest Medical Specialists, P.A.

REQUEST FOR FMLA/SHORT TERM DISABILTY FORM COMPLETION

DATE:

PATIENT NAME:	**PHONE:**
DATE OF BIRTH:	**SSN:**

REASON FOR REQUEST:

- ❑ History of skin cancer
- ❑ Surgery
- ❑ Other (please explain) _____

DATES REQUESTED FOR LEAVE: **TO**:

When paperwork is complete what would you like us to do:

- ❑ Leave at front desk to pick up
  LOCATION: _____
- ❑ Mail
  ADDRESS: _____
- ❑ Fax
  NUMBER: _____

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.

OFFICE USE ONLY

PAYMENT:	**APPROVED:**	**COMPLETED BY:**	**COMPLETION DATE:**