Date_____

Family Medical Center of Hart County
Information required for completion of Family Medical Leave (FMLA), Disability, and Time Loss

!!PATIENT- COMPLETION OF YOUR FMLA FORM WILL BE DELAYED IF THE FOLLOWING INFORMATION IS NOT COMPLETED IN FULL!!

1. **There will be a $20.00 charge for completion of forms.** Payment is required prior to completion.
2. **Complete the patient portion of your FMLA form**. Failure to complete the patient portion will cause the form to be returned to you and will delay completion**.**

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1. Patient name _____Daytime phone_____

2. Name of person requesting FMLA, if other than patient _____

   A. Relationship to patient_____ Daytime phone _____

3. Is this a: _____ new FMLA _____ a request to extend a current FMLA

   A. Reason for extension:_____

4. Condition(s) causing absence from work :_____
   _____

5. List dates patient/person was unable to work:

   _____/_____/_____/_____/_____/_____

6. Date(s) patient/person returned to work
   A. Date returned full time with no work restrictions _____
   B. Date returned with restrictions _____
   C. Date returned to less than full time with no work restrictions _____
   D. Date returned to less than full time with restrictions _____

7. **<u>Will you need FMLA for Intermittent Absences (non-continuous FMLA leave)?</u>**
   <u>Intermittent leave</u> refers to FMLA leave taken in blocks of time instead of continuous time off. Examples: recurring doctor's appointments for a specific condition, therapy by a healthcare provider, chemotherapy or recurring medical conditions such as seizure disorder, asthma.
   A. How many times per week do you estimate you will need to be absent?

   Number of _____absences per week or _____absences per month with an average length of time for a single absence _____ (hrs or days)

8. Are you being treated for this condition by an outside provider? yes or no
9. If yes, provide doctor's name _____
10. Future scheduled appointment dates for above provider_____

Handle form as follows: _____ mail to patient/requester, _____patient will pick up on _____
_____ send to employer: Employer/contact name_____
Employer fax number_____
Employer address_____

Allow a minimum of "four" working days for completion. *Revised 8-2011, 3-2013, 1-2016*