

Advanced OBGYN

FMLA/STD Form Request

*Please complete this request for each form you turn in. Missing information may delay the completion of your paperwork. Payment must be received before forms can be completed. Please call 256-881-9997 or visit the office to prepay for your paperwork.

ALL PAYMENTS MUST BE PAID WHEN FORMS ARE SUBMITTED.

Form Types: FMLA / Disability / Return to work / Physician Statements/Etc.

\$50.00 charge for the first form

\$25.00 charge for each additional forms

Patient Name: _____

Phone Number: _____

Date of Birth: _____

Forms are for: (Please Circle One) Self Spouse Family Member Other

Spouses Name: _____ Family Members Name: _____

Other: _____

Please only complete one of the categories below.

Maternity - Please check box for type of delivery if known

Vaginal Delivery: We can only medically cover you for **6 weeks. Due Date:** _____

C/Section: We can only medically cover you for **8 weeks. Due Date:** _____

Gyn Surgery - Please enter date of surgery

Surgery Date: _____

How do you want to receive your form(s)

Please check box and enter the required info needed below:

Fax: _____ **Email:** _____

Pick-up Forms: Call Ph # when forms ready: _____

I authorize Advanced OBGYN to release my forms to the following below:

For email delivery method please read and initial below for confirmation.

_____ I understand that email is not a secure method of communication and accepts the risk of unauthorized access or disclosure of my personal health information.

Signature: _____ Date: _____

Please allow 7 business days for paperwork to be completed.

For Office Use Only

Pmt Collected & Posted by: _____

Forms Completed & Scanned By & Date: _____

Charge Posted & Payment Applied on: _____

Notes: _____