Date Paid_____/Initials_____ ☐**Medicaid NO CHARGE**

MRN:_____

DEKALB HEALTH
MEDICAL GROUP

FMLA/SHORT-TERM DISABILITY FORM REQUEST

DATE: _____ NAME OF PHYSICIAN SEEN FOR REQUEST: _____

NAME OF REQUESTER: _____ DOB: _____

STREET ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____

EMPLOYER OF PERSON RECEIVING FMLA: _____

REQUEST IS FOR:

☐ **SELF *OR* ☐TO CARE FOR FAMILY MEMBER (NAME: _____ DOB: _____)**

****

PLEASE PROVIDE A BRIEF DESCRIPTION OF DISABILITY AND/OR ACCIDENT WITH DATES BELOW:

_____

_____

_____

☐ **CONTINUOUS**

LAST DAY WORKED: _____ ESTIMATED RETURN DATE: _____

☐ **INTERMITTENT**

LENGTH OF NEED: _____

FIRST DATE OF TREATMENT FOR THIS ILLNESS OR INJURY: _____

MOST RECENT DATE OF TREATMENT FOR THIS ILLNESS OR INJURY: _____

DATE OF NEXT PHYSICIAN VISIT: _____

WERE YOU REFERRED TO ANOTHER PHYSICIAN? ☐ NO ☐ YES

NAME OF PHYSICIAN YOU WERE REFERRED TO? _____

ARE YOU PARTICIPATING IN ANY TYPE OF THERAPY? ☐ NO ☐ YES

PLEASE NOTE ANY OTHER INFORMATION THAT MAY BE HELPFUL TO ASSIST US IN COMPLETION OF FORM: _____

_____

******PLEASE NOTE THERE IS A $20.00 FEE DUE FOR PROCESSING OF FMLA FORMS (Please inform staff if you are a Medicaid Beneficiary as fees will be waived). TURNAROUND TIME ON THESE FORMS IS APPROXIMATELY 7-10 DAYS.******