

Violet Crown

FMLA / DISABILITY FORM COMPLETION REQUEST & PATIENT AUTHORIZATION

Please allow 7-10 days for completion**

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____
Phone: _____ Email: _____

TYPE OF REQUEST

Forms are for: ☐ SELF ☐ SPOUSE / FAMILY MEMBER Type: ☐ FMLA ☐ Short-Term Disability ☐ Return-to-Work ☐ Physician Statement ☐ Other:

Employer: _____ Leave / Disability Company: _____
Claim / Case #: _____ Employer Contact: _____

OB / GYN LEAVE INFORMATION

Maternity: ☐ Pregnant - EDD: _____ ☐ Delivered - Date: _____ ☐ Vaginal Delivery ☐ Cesarean Delivery
GYN Surgery / Procedure: _____ Date: _____
Requested leave: Start: _____ End: _____ ☐ Continuous ☐ Intermittent ☐ Reduced Schedule
Requested dates are not automatically approved. Violet Crown OBGYN will certify only leave, restrictions, extensions, or return-to-work status medically supported by the treating provider and medical record.

WHERE SHOULD THE COMPLETED FORM BE SENT?

Select one: ☐ FAX ☐ MAIL ☐ PICK UP IN OFFICE ☐ SECURE ELECTRONIC DELIVERY (when available)

Recipient / Organization: _____ Attention: _____
Fax: _____ Phone: _____
Mailing Address: _____ City / State / ZIP: _____

PATIENT AUTHORIZATION

I authorize Violet Crown OBGYN to use and disclose health information reasonably necessary to complete and transmit my FMLA, disability, leave, return-to-work, or related certification to the recipient identified above. This may include pregnancy status, estimated due date, delivery date/type, relevant diagnoses or conditions, surgery/procedure information, medically supported leave dates, work restrictions or limitations, intermittent or reduced-schedule leave, and return-to-work status. I understand this authorization is voluntary; I may revoke it in writing except to the extent action has already been taken in reliance on it; information disclosed may be redisclosed by the recipient and may no longer be protected by privacy law; and I may request a copy of this signed authorization. This authorization expires upon completion of this request and directly related clarification, or 180 days after signature, whichever occurs first, unless I specify an earlier date/event: _____.

Patient / Legal Representative Signature _____ Date: _____
Printed Name (if representative) _____ Relationship / Authority: _____

\$45 FMLA / DISABILITY FORM COMPLETION FEE

A \$45.00 administrative form-completion fee is due before processing begins. This fee is for completion of FMLA/disability paperwork and is separate from any medical-record copy fee. Additional or substantially revised forms may require an additional form-completion fee. Please allow 7-10 business days after the completed request, required paperwork, and payment are received. Urgent completion is not guaranteed.

☐ I acknowledge the \$45 form-completion fee. Patient/Representative Initials: _____

VIOLET CROWN OFFICE USE ONLY

Date Received: _____ ☐ Authorization Complete Payment: ☐ \$45 Form Fee Paid Date: _____
Date Completed: _____ Staff Initials: _____ Delivery: ☐ Fax ☐ Mail ☐ Office Pickup ☐ Secure