Carolinas HealthCare System

Obstetric and Gynecology
Medical Leave and Disability Form

1. This form pertains to: FMLA, disability, out of work notes and any other form that releases your disability information to other parties. Please indicate here if the physician has put you out of work for a medical reason: Yes _____ No _____ Date last worked _____ Reason for leave _____

   _____

   This information will be confirmed with your provider.

2. All FMLA forms need to be turned into us by your 36th week of pregnancy or as soon as a medical problem causes a qualifying disability status or prior to surgery.

3. Forms take 10-14 business days to complete.

4. Please indicate how to route your forms after they are completed:

   CHOOSE ONE

   a) Fax to: Name and Fax Number _____

      _____

   b) Mail to: Name and Address _____

      _____

   c) Pick up from our office _____ Name of person picking up forms _____. Phone number to contact you or delegated person indicated above to pick up forms when completed _____.

5. Please be advised that your forms can only be released with your written permission. Signing this form gives us your permission to release medical information to other parties. For your protection, we do not give out verbal information to employers or insurance companies. All correspondence must be in writing, please have them fax all requests to the attention of the Disability Department at _____.

   I have read and understand the contents of this form.

Signature _____

Patient name (please print) _____

Patient account number _____

Date _____