

DISABILITY / LEAVE FORM COMPLETION

Note: Patient to complete entire form

PATIENT: _____

DATE: _____

Office Use Only:

Physician: _____

RECEIVED BY: _____

Name of Forms: _____

of Forms: _____

Disability Start Date: _____

Total Fee: \$ _____

Disability End Date _____

Paid: \$ _____

FORM IS TO BE:

____ Fax to phone #: _____

____ Mailed to Patient

____ Picked up by: _____

____ Please call _____ when ready to be picked up. Phone#: _____

____ Mail form to insurance company at the address on the form or to the following address:

Company _____

ATTN: _____

Street: _____

City _____ State _____ Zip: _____

Additional Information: _____

A minimum fee of fifteen dollars (\$15.00) is required for completion of all forms. Payment is expected at the time the form is dropped off or prior to sending to any authority.

Please allow 5-7 business days for form completion. Also note that it may take 3-5 days for mail delivery.

Thank you

Patient Signature