

TRI-COUNTY SURGICAL ASSOCIATES, P.A.

DISABILITY AND FAMILY MEDICAL LEAVE INFORMATION FORM

PLEASE READ CAREFULLY

1. The patient must complete **their** portion of the form completely. If you have questions while filling out your portion of the form, please contact your employer or human resources department. Unfortunately, we do not have the staff or time to assist you with this process.
2. **We cannot accept faxed forms from your insurance company.** The FMLA form should be faxed **to YOU**. Once you have completed your portion of the form, please bring the form to our office to complete.
3. All forms must have the **first day** the patient missed work as well as the **date the patient is expected to return to work.**
4. The patient must sign the form allowing Tri-County Surgical Associates to release medical information.
5. **PLEASE ALLOW AT LEAST 5 WORKING DAYS TO COMPLETE THE FORM.** In order to properly complete your disability or FMLA form, our staff must completely review your medical records, therefore the form cannot be completed the same day it is brought to the office.

Name of patient (please print): _____

Date last worked: _____ Date expected to return to work: _____

Date(s) of hospitalization: _____ Date form received: _____

Phone number of patient: _____ Fax number (to fax form): _____

Signature of patient: _____

THERE WILL BE A \$20.00 CHARGE FOR EACH INSURANCE FORM COMPLETED