

Moreland OB/GYN Associates, S.C.
Family Medical Leave (FMLA) and Disability Cover Sheet

Name: _____ Date of Birth: _____

Physician: _____

Is this paperwork for the patient or spouse: _____

Please make sure the patient information section of your medical leave paperwork has been completed and signed. We need your signature in order to release information.

Notice: It is the practice of Moreland OB-GYN to complete paperwork for the time off that is medically necessary for each incident, unless discussed with the physician.

FOR PREGNANCY (If applicable):

Estimated Due Date: _____

First day of medical leave: _____

If prior to Due Date reason: _____

Anticipated amount of time off: _____

Scheduled Cesarean Section date: _____

Date you anticipate returning to work: _____

FOR SURGERY (If applicable):

Date of Surgery: _____

First day of medical leave (if different): _____

Anticipated amount of time off: _____

Date you anticipate returning to work: _____

Submitting Paperwork:

Check all boxes that apply. If left blank, forms will be faxed to the number on the form.
Please write in any phone numbers.

Fax form to: ATTN: _____ Fax number: _____

Pick up form at the Waukesha location (1111 Delafield Street, Suite 120)

Pick up form at the Oconomowoc hospital location (785 Summit Ave, Suite 203)

Phone number to call when ready for pick up: _____

MyChart form to patient

Please understand that Moreland OB-GYN Associates, S.C. will provide the information within **7-10 business days** from the original request. If you have any questions, please feel free to contact our office.

-----Employee use only-----

Patient Label: _____

Employee initials: _____

Date: _____

Disability Log