Division of Gynecologic Oncology

E-MRN ___________________

Disability/ FMLA Information Sheet

Please fill out this form to help us complete your disability paperwork. We ask that you allow us at least 7 business days to complete this request.

Date: ____________

Patient Name: ____________________________________**Date of Birth** ___________

Name of person completing form _________________________________

Relation to patient: _________________________

Telephone#: ________________________________

Date of surgery or disability: _________________

Hospitalization dates: _________________**to** _________________

First day out of work: ___________________ **Date of return to work** ___________

Please check one:

______ **Please call me at** _________________________, **I will pick up the forms.**

______ **Please fax to (company and fax#)** _________________________________

____

______ **Please mail form to** ____

Please sign here: ____

Thank you for helping us to complete your insurance forms. Please call us at (585) 442-8020 with any questions or additional information regarding your request.

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