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 311)**
☐ **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 ☐