Comprehensive OB/GYN, LLC
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Coral Springs, FL 33065
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REQUEST FOR DISABILITY PAPERWORK (FMLA) TO BE COMPLETED BY PATIENT

PLEASE BE ADVISED THERE IS A *ONE-TIME $25 FEE* FOR COMPLETION OF PAPERWORK

Patient Name:_____

Date of Request:_____ **Physician:**_____

1. Reason you are applying for disability benefits: _____

   _____

   _____

   _____

2. Please indicate specific dates you are filing for disability benefits:

   Beginning Date:_____ End Date:_____

3. If you plan to work part-time, how many hours a day will you work?

   _____

4. What restrictions do you need specified regarding your job duties?

   _____

   _____

Patient Signature:_____

$25.00 Payment is due at the time this form is completed.

PLEASE ALLOW 7-10 BUSINESS DAYS FOR YOUR PHYSICIAN TO COMPLETE THIS FORM

**********TO BE COMPLETED BY OFFICE STAFF ONLY**********

Method of Payment:_____ Date:_____ Staff Name:_____