AUSTIN REGIONAL CLINIC

FMLA, SHORT TERM DISABILITY, AND RETURN TO WORK

Person obtaining forms: _____

Patient's name (please print) _____ Patient's Date of Birth _____

Patient MRN (office use only) _____ Provider _____

- Please be advised there is a **$25.00 processing fee** for all paperwork being completed by the provider/clinical staff and allow **7-10 business days** for your forms to be completed.
    - If a request is made to complete additional paperwork for a separate medical condition, you may incur an additional $25.00 fee.
- Please note: we are not able to complete paperwork for employment absences incurred prior to your first visit with the provider.

1. Is this related to an injury? (Circle one): YES NO
2. Is the injury work related? (Circle one): YES NO
3. Date you were advised to stop working? _____
4. Date of surgery OR for pregnancy date of delivery? _____
5. Date you expect to return to work (if unknown write the date of your next office appointment with your doctor): _____
6. Provide a brief description of your job duties: _____
7. What is your normal work schedule? _____
    - List dates and/or hours you are requesting off: _____
8. Will your employer let you return to work with restrictions? (Circle one): YES NO
    - If yes, what restrictions will you require? _____
9. Will you need intermittent or continuous time off? _____
10. Is there anything else to note about the situation? _____

☐ I would like to pick up my completed forms, please call me at ph. _____ when ready.

☐ Send completed forms to my MyChart.

☐ I would like my forms faxed to the following: Name: _____ Fax: _____

I hereby give Austin Regional Clinic permission to release my personal information on associated forms to the above party. I also understand there is a $25 fee for having forms completed.

Signature of Patient: _____ **Date:** _____

***Internal Use Only**:*

Request Taken By: ☐ *TRIAGE CALL ENTERED*

BO: Drop off Date: _____ ***Due Date:*** _____ ***Charge Entered Date:*** _____

Payment Date: _____ ***OR*** ☐ ***Patient will pay at pickup***

☐ ***Clinical: Encounter signs/sent to scan on:*** _____