Patient #________________________

Short Term Disability/FMLA Forms
(Please allow up to 7 business days for your form(s) to be completed.)

Patient's Name:_________________________ Doctor:___________________

Date of Birth:___________________________

Phone number to be reached during normal business hours: _________________________

If your form is for disability/leave of absence:
When was (or when will be) your first day out of work? _____________________

How long do you and your doctor anticipate that you will be out of work?
(Or if you have already returned to work, on what date did you return?) _____________________

- If you would you like your form to be faxed to your insurance carrier or employer, please make sure the fax number is on the form. If it is not on the form, please provide the fax number:

  Fax #:_______________________________
  Attention: ____________________________

- If you would you like your form to be mailed to your insurance carrier or employer, please make sure the mailing address is on the form. If it is not on the form, please provide the address:
  ____
  ____
  ____

- If you would like your form to be mailed back to you, please write your mailing address:
  ____
  ____
  ____

- If you would like to pick up your form at our office once it is completed, please check which office: (You will receive a phone call at the number written above once your form is ready to be picked up.)

☐Glenwood ☐Garner ☐Cary ☐Durant Rd.

Authorization to release information: I hereby authorize Raleigh Orthopeadic Clinic to release information to my insurance carrier(s) or employer, as indicated above, concerning my illness and treatments.

Signature of Patient:______________________________ **Date**:________________