GynoFitMD
Women's Health & Medical Weight Loss Expert

Disability & FMLA Form

Last Name: _____ First Name: _____ DOB: _____

Which Company is requesting the form: _____

Circle One: ☐ **DISABILITY** | ☐ **FMLA**

Please mark your selection of how you would like to the completed forms to be returned to you:
☐ Please call when the form is ready for pick-up.
☐ Please fax the completed form to fax #: _____

What is the reason you need disability / FMLA paperwork filled out:

Dates you are requesting disability / FMLA:	to
Who is the treating physician for this medical problem:	

PLEASE INITIAL & SIGN ALL AREAS BELOW	
	You have already completed your portion on the disability form that is required by the patient to complete.
	You have paid the $25 fee.

Patient or authorized representative signature: _____ Date: _____

GynoFitMD Staff Initials: **$25.00 Paid** _____ Date Paid: _____