



Women's Health Specialists of Montgomery County PA

Gynecology-Gynecologic Oncology
6301 Executive Boulevard
Rockville, MD 20852
Phone: (301) 770-4967

FMLA & Disability Intake Form

Patient Name: _____ Today's Date: _____

Surgeon (circle one) Steren / Barter / Young / Levav / Snyder

First date of leave: _____ Expected return to work date: _____

Please return form to me by:

_____ (1) I will come to pick up

_____ (2) mail to me at this address _____

_____ (3) Fax to me (fax number) _____

_____ (4) Mail to other address _____

_____ (5) Fax to other (fax number) _____

Attn: _____

****Please make sure this is a secure fax number. Forms contain your personal health information****

Please allow a minimum of two weeks for completion.

I am aware that there is a \$50.00 charge for each disability form requested which will be processed when the form is completed. The fee for FMLA forms will be \$25.00.

Authorized Signature

Date

I am enclosing my credit card information so that I may have my credit card charged at the time of completion or I am attaching a check.

Credit Card #: _____ MasterCard / Visa (circle)

Expiration Date: _____ 3 digit security code _____

Name on Card: _____ Billing Zip Code: _____

Authorized Signature

Date