BLOUNT ORTHOPAEDIC ASSOCIATES

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DISABILITY/INCOME REPLACEMENT/FMLA REQUEST FOR FORM COMPLETION

- In order for our office to complete your disability forms the following information is NECESSARY in order to insure your benefits will be processed timely and accurately.
- FOR CONFIDENTIALITY REQUIREMENTS – the PATIENT'S signature must appear on the disability form in order for us to release the information. Please make sure the PATIENT has FULLY completed his/her section of the form.
- We process forms in the order we receive them – the process MAY take 7-10 business days for completion. FMLA forms are completed by the SURGEON. Disability forms are completed by a staff member BASED ON THE INFORMATION (Physician note and work slips) in your chart.

DATE FORM RECEIVED IN OFFICE: _____

PATIENT NAME _____ DATE OF BIRTH_____

WHAT BODY PART IS THIS FORM FOR: Right / Left _____

FIRST DAY OFF WORK: _____/_____/_____

IF INJURY, WHEN DID THE INJURY OCCUR: _____/_____/_____

DID INJURY HAPPEN AT WORK? ☐ YES ☐ NO

IF YOU HAVE RETURNED TO WORK, WHEN DID YOU RETURN? _____/_____/_____

WHEN IS YOUR NEXT APPOINTMENT? _____/_____/_____

ARE YOU SCHEDULED FOR SURGERY: ☐ YES, date of surgery:_____ ☐ NO

PLEASE CHECK ONE OF THE FOLLOWING:

☐ PLEASE FAX FORM TO: NAME _____ FAX: _____

☐ PLEASE MAIL TO MY HOME: _____

☐ PLEASE MAIL TO MY INSURANCE COMPANY:

_____

☐ I WILL PICK UP FORM IN OFFICE ☐ GLENDALE OFFICE ☐ CEDARBURG OFFICE

☐ PLEASE MAIL TO MY EMPLOYER: _____

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