

Date \_\_\_\_\_

**Family Medical Center of Hart County**  
**Information required for completion of Family Medical Leave (FMLA), Disability, and Time Loss**

**!!PATIENT- COMPLETION OF YOUR FMLA FORM WILL BE DELAYED IF THE FOLLOWING INFORMATION IS NOT COMPLETED IN FULL!!**

1. **There will be a \$20.00 charge for completion of forms.** Payment is required prior to completion.
2. **Complete the patient portion of your FMLA form.** Failure to complete the patient portion will cause the form to be returned to you and will delay completion.

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1. Patient name \_\_\_\_\_ Daytime phone \_\_\_\_\_

2. Name of person requesting FMLA, if other than patient \_\_\_\_\_

A. Relationship to patient \_\_\_\_\_ Daytime phone \_\_\_\_\_

3. Is this a: \_\_\_\_\_ new FMLA \_\_\_\_\_ a request to extend a current FMLA

A. Reason for extension: \_\_\_\_\_

4. Condition(s) causing absence from work : \_\_\_\_\_  
\_\_\_\_\_

5. List dates patient/person was unable to work:  
\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

6. Date(s) patient/person returned to work
  - A. Date returned full time with no work restrictions \_\_\_\_\_
  - B. Date returned with restrictions \_\_\_\_\_
  - C. Date returned to less than full time with no work restrictions \_\_\_\_\_
  - D. Date returned to less than full time with restrictions \_\_\_\_\_

7. **Will you need FMLA for Intermittent Absences (non-continuous FMLA leave)?**  
Intermittent leave refers to FMLA leave taken in blocks of time instead of continuous time off. Examples: recurring doctor's appointments for a specific condition, therapy by a healthcare provider, chemotherapy or recurring medical conditions such as seizure disorder, asthma.

A. How many times per week do you estimate you will need to be absent?  
  
Number of \_\_\_\_\_ absences per week or \_\_\_\_\_ absences per month with \_\_\_\_\_ an average length of time for a single absence \_\_\_\_\_ (hrs or days)

8. Are you being treated for this condition by an outside provider? yes or no
9. If yes, provide doctor's name \_\_\_\_\_
10. Future scheduled appointment dates for above provider \_\_\_\_\_

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**Handle form as follows:** \_\_\_\_\_ mail to patient/requester, \_\_\_\_\_ patient will pick up on \_\_\_\_\_  
\_\_\_\_\_ send to employer: Employer/contact name \_\_\_\_\_  
Employer fax number \_\_\_\_\_  
Employer address \_\_\_\_\_

**Allow a minimum of "four" working days for completion.** Revised 8-2011, 3-2013, 1-2016