Orthopedic Specialists & Sports Medicine

An OrthoAlliance Partner Practice

FMLA Request for Form Completion

Phone: (740) 788-9220 Fax: (740) -788-9226

Pre-Payment Is Required. Please allow 7-10 business days for completion of form(s).

A fee per form is due prior to completion of the form(s). The Fee Schedule is as follows:
$25 for the initial form, $25 for updates for the same qualifying condition, plus any applicable sales tax.
You will be contacted be OSSM with payment options after you return this paperwork.

All information on this form is required to be filled out to and legible in order to complete your FMLA request.

Date:____/____/_____

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member – Name:_____

Patient Name:_____
(Last) (First) (Middle/Maiden)

Address:_____

City: _____State: _____ Zip: _____

Social Security #: _ _ _ - _ _ _ - _ _ _ _ Date of Birth: _ _ / _ _ / _ _ _ _ Telephone Number: _ _ _ - _ _ _ - _ _ _ _

Email Address: _____

Physician: _____ Body Part:_____

Date Injury/Problem Began:_____ Last Day Worked:_____

For Patients requesting leave for themselves, what is the date(s) that you anticipate returning to work?: _____

Check a Reason: ☐ Continuous Leave ☐ Surgery and Post Op - Treatment ☐ Intermittent Leave

For Family Members requesting leave, what date(s) do you anticipate being out of work: _____

I authorize Orthopedic Specialists & Sports Medicine to release the completed form(s) and/or the use and disclosure of my individually identifiable health information to:
Name/Organization: _____
Address:_____
City: _____ State: _____ Zip: _____
Telephone Number: _ _ _ - _ _ _ - _ _ _ _ Fax Number: _ _ _ - _ _ _ - _ _ _ _
Email Address: _____

Please check your preferred method of release:
☐ Fax the form to the number provided above
☐ Email the form to the above email address
☐ Mail the form to the patient's address
☐ Mail the form to the Name/Organization above

I understand that: I may refuse to sign this authorization and that is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving this revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ **If I do not specify expiration this authorization will expire in 90 days.** If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. _____(Initial)

Signature: _____Date:_____
Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other:_____