Date_____ Account #_____

FORMS MUST BE PAID FOR PRIOR TO BEING COMPLETED

ALL QUESTIONS MUST BE COMPLETED TO HAVE FORM FILLED OUT

FORMS CAN TAKE UP TO TWO WEEKS TO BE COMPLETED
PATIENTS PLEASE INITIAL HERE: _____

Disability Form Questionnaire: THIS MUST BE ENTIRELY FILLED OUT TO ENSURE YOUR FORM IS COMPLETED TIMELY AND ACCURATELY

Patient:_____ DOB: _____

Treating Physician: _____

Are you working? YES OR NO **If Yes:** FULL DUTY OR LIGHT DUTY

If NO, what is the last day you worked _____
If YES, what is the last day you are planning to work _____

Are you scheduled for Surgery? YES OR NO **Date of Surgery: _____**

Is this a Continuous Leave or Intermittent Leave? _____
(Continuous Leave: Absent for 3 consecutive business days or longer and has been treated by a doctor)
(Intermittent Leave: Absent in separate periods of time due to an injury or illness and has been determined by a doctor)

Expected Return to Work Date: _____

If you are requesting a HANDICAPPED parking permit, A WALKING DEVICE MUST BE USED, PLEASE STATE THE TYPE OF DEVICE: _____

When form is completed please pick ONE of the following:

- Call Patient to pick up at # _____
- Mail Form to Patient _____
- Email Form to Patient _____
- Fax Form to # _____

PAYMENT FOR EACH FORM IS $15 _____ PAID & EMPLOYEE INITIALS