

FMLA/Disability Paperwork Request

**This form must be completed for *EACH* request to complete FMLA or Disability paperwork.
We will not consider your paperwork until *ALL QUESTIONS* are answered.**

***The first form completed is complimentary when related to surgery.
Any additional forms or forms NOT related to surgery will require a \$50 Fee due at completion.***

Patient Name: _____ Date of Birth: _____

1. Start Date: _____ to Planned End Date: _____

2. Type of leave you're requesting (**Choose One**):

☐ Completely off work for one continuous period (usually for outpatient surgery)

☐ Reduced Schedule/Part Time Status

How many hours per day do you plan to work? _____

How many days per week to you plan to work? (List specific days if applicable)

☐ Intermittent Time-Off

(I need to miss part or a whole day periodically for flare-ups)

How often do you expect to require time off for flare ups?

_____ times per ☐ week / ☐ month / ☐ year

To last: _____ ☐ hours / ☐ days each time

☐ Reduced Duties Only

(I plan to work, but need special accommodations or limited duties)

3. Will your job allow you to wear a protective boot (i.e. cam walker) while working? ☐ Yes ☐ No

4. Will your job allow you to work with reduced duties or limitations? ☐ Yes ☐ No

If yes, describe your basic duties: ☐ See attached job description

5. If you answered "yes" on question 4, can you complete all of these duties? ☐ Yes ☐ No

If no, list specific duties you CANNOT DO:

This request must be submitted a minimum of 3 business days before it is due.

Hand-deliver or email to awitcher@infinityfootandankle.com along with your FMLA or Disability paperwork.