JUA JACKSON UROLOGICAL ASSOCIATES, PC

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COMPLETION OF DISABILITY AND FMLA FORMS

Please allow 7-10 business days at time of payment for your form to be completed.

Jackson Urological Associates will not be able to complete and return all forms until fees are collected and all questions below are answered.

To maintain the integrity of privacy protection guidelines, the patient must complete and sign the patient portion of this form. **The fee charged to complete forms is $10 per physician signature required.** Please be prepared to pay this fee at the time the form is presented for completion.

To be completed by patient:

Patient's Name _____ Date of birth _____

Did you have surgery/Is surgery anticipated? Yes / No Procedure date _____

Physician _____ Last day of work _____ Estimated return date _____

Type of form: FMLA _____ Insurance Policy _____ Short Term Disability _____ Long Term Disability _____

Other (please specify) _____

This form is for: Patient _____ Spouse _____ Other Family Member ____ Relationship to patient _____

Full name and DOB if form is not for patient _____

Where to send completed forms:

Mail ___ Address _____

Fax ___ Fax Number _____ATTN to: _____

Pick up ___ Number to call _____

Patient signature _____

Your signature authorizes JUA to release requested information to chosen organization.

Clinic use only.

Patient ID _____ Amount paid _____

Received by _____ Date received _____