Consultants in Women's Healthcare, Inc.

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MEDICAL FORMS **Todays' Date** ________________

Please answer the following questions, which will assist in the accurate completion of your insurance, disability, and/or family medical leave forms.

Patient name: ____

Form is for (circle one): Patient Spouse Other: ____________________

1. Please complete and sign your portion of the form (if required on your form).
2. When will be or was your first day off work? ______________
3. When do you anticipate returning to work? ______________
   Please note YOU must be aware of YOUR company's policy for return to work.

   Keep in mind, under normal circumstances, you will be under your doctor's care:

Vaginal delivery	6 weeks
C-section delivery	8 weeks (6 weeks only for some disability carriers)
Post-operative	1 day to 6 weeks (depending on surgical procedure)

4. If this form is only for decreasing work hours temporarily, what are the hours you will be working and the duration of the reduced hours?
5. How should we handle this form upon completion of the physician information?
   a. __________ Mail it to your home address.
   b. __________ Mail or fax it back to the company for whom the form is being completed
      Company: ____________________ Fax #: ______________________
   c. __________ Leave it at front desk and it will be picked up at your next office visit.
   d. __________ Notify you when the form is completed, and you will pick it up from the front desk.
      If this option is chosen, please list the phone number where we can notify you when the form is ready to be picked up. Phone# _______________
6. There is a $20.00 fee for completing each set of forms. This fee is due prior to the completion of the forms. You will pay:
   □ By cash or check □ By Visa, Mastercard, or Discover

I give my consent for CWHC to release necessary medical information to the employer and/or insurance company requesting the information.

Signature: ____ Date: ____________________________

Internal use only:
PMT received: ______

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