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in affiliation with FOA

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FORMS COMPLETION REQUEST

Please Print Legibly

Patients are required to complete this form to request the provider to complete FMLA, short term disability, and other forms.

There is a charge of $30.00 for the completion of all forms.

Please allow 10-14 business days for the completion of all forms.

Patient's Name: _____

MRN#_____

Date of Birth: mm/dd/yyyy _____/_____/_____

Today's Date: _____/_____/_____ Contact Phone: _____

Doctor's Name of Physician Assistant: _____

Please select one (s) below which applies:

- □ I request to be called at the above number when forms are completed.
- □ I will pick the form(s) up at the Fredericksburg location.
- □ I will pick the form(s) up at the Stafford location.
- □ I will pick the form(s) up at the Spotsylvania location.
- □ I would like the form(s) faxed to: (complete information below).
- □ I would like the form(s) mailed to: (complete information below).
- □ Estimated return to work is: _____/_____/_____

Fax Number: _____

Attention: _____

Address: _____

_____

City & State: _____

Zip Code _____ Phone #_____

Receptionist's Initials _____