COMPREHENSIVE WOMEN'S HEALTHCARE

DISABILITY FORM

Patient Name _____D.O.B_____

Which Company is requesting the form: _____

CIRCLE

Please call when form is ready to be picked up

Or

The office is to fax to # _____

What is the reason you need disability paperwork filled out _____

_____

_____

Dates you are requesting for disability _____ to _____

Who is the treating Physician for this medical problem _____

INITIAL

_____ **You have already completed your portion on the disability form that is required by the patient to complete.**

_____ **You have paid your $35 form fee.** **$35.00 Paid** _____
Employee Initial

_____ **You are aware this form may take up to a week to complete. If needed sooner additional fees may apply.**