Women's Health Associates
A division of Mid America Physician Services, LLC

Leah Ridgway, M.D.
Evelina Swartzman, M.D.
Ana Martinez, M.D.
Reagan Wittek, M.D.
Amy Giedt, M.D.
Kimberly Matthews,

Phone: (913) 677-3113
Fax: (913) 677-4514

9119 W. 74th St., Ste. 300
Shawnee Mission, KS

5401 College Blvd., Ste. 100
Leawood, KS 66211

FMLA / SHORT TERM DISABILITY FORM

We are happy to complete disability and FMLA forms for you. **The cost of FMLA will be $25 per set**. This must be paid in advance. We will only complete the physician section of the forms. Please leave this completed form along with your disability/FMLA form(s) and your payment with the receptionist.

PLEASE ALLOW 10 BUSINESS DAYS FOR COMPLETION OF THESE FORMS. THANK YOU!

Patient Name: _____ Date of Birth: _____
Physician: _____
Forms being completed for: ❒Self ❒Spouse ❒Other _____

Dates you are requesting off:
Continuous dates (if required): From: _____ To: _____
Intermittent/hours/dates (if required): _____, _____ ,_____, _____
Date you plan to return to work: _____
(Please note that the paperwork will reflect the medically necessary time off. ACOG standard time off is 6 weeks for vaginal delivery and 8 weeks for C-Section)

If you worked a reduced schedule, is/was this due to complications? ❒ Yes ❒ No
If yes, please list complication(s): _____
What date did you begin a reduced schedule? _____
(Please know that if your schedule was reduced for a reason other than medical complications explained by your doctor, your time may not be covered)

DELIVERY INFO (IF DELIVERED) OR SURGERY INFO:
Date of delivery: _____ Type of delivery: ❒ Vaginal ❒ Cesarean
Which hospital did you deliver? _____
Other surgical procedure: _____ Hospital: _____
Date of hospital admission: _____ Date of hospital discharge: _____
Last date worked: _____

PAPERWORK PICK-UP
How would you like for the paperwork to be returned (check all that apply)
❒ Fax to: _____
❒ Pick up: _____
❒ Call when ready: phone number: _____
❒ Mail: address: _____
_____

SECTION BELOW FOR OFFICE USE ONLY

Proof of Condition: Date:
❒ Positive urine pregnancy _____
❒ Sonogram, early _____
❒ Positive blood test _____
Expected delivery date _____
LMP _____

❒ Payment Collected from Patient - Amount $ _____
Method: ❒Cash ❒Ck#_____ ❒Credit/Debit
Date _____