Disability Form Instructions

In order to assure a smooth process, please answer the following questions:

Patient's Name:____

Date of Birth:____

Do you want to have your disability form(s):

Faxed to: ____

Mailed to:____

____

____

You will pick up:_______________________________________

Other:____

Please list the dates you or your family member will be/were out of work:____

A one time charge of $20.00 will be assessed at the time the forms are completed. Payment must be made when the form is dropped off for completions.

Thank you,

The Staff at First State Women's Care

Payment:____________

Date:_______________