HYPOSPADIAS SPECIALTY CENTER

Office Policies for Leave paperwork or Short Term Disability Forms

- It is the patients responsibility to bring in, fax, or email the correct forms to our office for completion by the medical staff.
- The patient or patient family is required to provide a copy of his/her job description with the paperwork in order to accurately complete the forms.
- The employee portion should be completed **prior** to providing the paperwork to our office.
- If help is needed, for a $35 fee, all forms can be completed with at least two weeks of time prior to the employer deadline date.
- If you would like the forms to be completed within 3 business days, there is a $60 fee.
- The fees must be payed to the front office staff at the time they are given to the office staff. Please call the front office to make the payment, or click the payment portal on the top right of the home page of hypospadias.com.
- Please understand, this is **not** a guarantee of approval through your employer.
- All forms will be faxed directly to your employer, but a copy can be emailed to you at your request. Please provide a fax number when the forms are brought to our office.

Patient Name: _____

Patient DOB: _____

Person requesting leave (name and relationship to patient):_____

Date of Surgery: _____

Requesting *continuous* time off from _____ through _____

Requesting *intermittent* time off from _____ through _____

Email or fax number where the paperwork should be sent:_____

Would you like a copy? If yes, email address:_____

☐ I would like to request the paperwork to be completed by the office and faxed to my employer within 2 weeks. I understand there will be a $35 fee.

☐ I would like to request the paperwork to be completed by the office and faxed to my employer within 3 business days. I understand there will be a $60 fee.

Is this time including HBO therapy?

Where are the treatments, and for what dates?_____

Job Title: _____

I, _____ have read and understand the leave or short term disability form policy of Hypospadias Specialty Center. I understand that this policy cannot be altered and if I do not agree with the policy, I understand that I may not have the forms completed by the Hypospadias Specialty Center.

_____ _____ _____

Print name (Person requesting the FMLA) Signature Date