DATE REC'D BY COSM & Initials _____
MRN_____
DOCTOR _____

MEDICAL, FMLA, & DISABILITY FORMS

PLEASE ALLOW UP TO 10 BUSINESS DAYS TO COMPLETE YOUR FORMS.

☐ **I elect to pay the $25 fee for each set of requested forms.**

☐ **I elect to pay the $50.00 fee for all forms completed within a 90-day window.**

****** This form must be completed in its entirety******

ACCIDENT/FMLA/DISABILITY FORM

Patient's Name: _____ DOB: _____
Patient Address: _____City_____State_____Zip_____
Daytime Phone # _____Secondary #_____
Concerning Which Body Part(s): _____
Job Title: _____
Job Physical Demands: _____
Date(s) Out of Work: _____Return to Work: _____

Request for: (this section does not apply for continuous leave, only intermittent or restricted)

☐ Intermittent Leave _____
☐ Restricted Work _____

*Form(s) will only be released via delivery method(s) selected below: *

☐ PICK UP FORM FROM (Circle): **Cary Pkwy Ortho** **Cary Ortho Spine** **Davis Drive** **Holly Springs**

☐ MAIL FORM TO PATIENT (Address) _____

☐ EMAIL FORM TO PATIENT (Email Address) _____

☐ FAX TO THE FOLLOWING:

COMPANY NAME: _____ PHONE #_____
ATTN: _____ FAX # _____

I hereby authorize the release of these forms and/or medical records from UNC Health Cary Orthopaedics to the individuals selected above.

Patient's Signature: _____Date: _____

YOU MAY REVOKE OR TERMINATE THIS AUTHORIZATION BY SUBMITTING A WRITTEN REVOCATION TO OUR OFFICE. THIS INFORMATION MAY BE REDISCLOSED BY THE RECIPIENT.

CARY ORTHOPAEDIC STAFF ONLY CASH/CHECK/CREDIT CARD $ _____ DATE: _____ CHARGES POSTED BY: _____ON_____