SANTA FE OB/GYN
FAMILY & MEDICAL LEAVE ACT (FMLA) FORMS

NAME: _____ DATE OF BIRTH _____

PATIENT INFORMATION PORTION OF THE FORM MUST BE COMPLETED BY YOU. MAKE SURE YOU SIGN THE "AUTHORIZATION" TO RELEASE INFORMATION LINE.

FOR PREGNANCY:

BEGINNING TO END DATE OF LEAVE: _____

FIRST DAY OF LAST MENSTRUAL PERIOD: _____

DUE DATE: _____

FOR SURGERY:

IS IT SAME DAY SURGERY, OR MAJOR SURGERY THAT REQUIRES STAYING OVER NIGHT IN THE HOSPITAL? _____

FIRST DAY OF LEAVE: _____

DATE RETURNING TO WORK: _____

HOW DO YOU WANT THIS FORM RETURNED TO YOU?

☐ **MAIL FORM TO**:

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

☐ **CALL WHEN FORM IS COMPLETED:** ☐ **FAX TO FAX NUMBER BELOW**
PHONE #_____ FAX # _____

I understand that Santa Fe OB/GYN will provide this information within 7 business days from the receipt of request, and that a fee of $20.00 will be charged to me for the completion of my FMLA form. I release the following information for the purpose of leave from my place of employment.

Signature_____ Date_____

Print Name_____