ANDOVER FAMILY MEDICINE

FMLA Information

Patient Name: _____ DOB: _____

Today's Date: _____ Patient's phone number: _____

Requested FMLA Start and End Dates: _____

Reason for FMLA: _____

_____

Requesting continuous or intermittent leave?: _____

Will you be able to work part-time during the FMLA period?: _____

Include any additional information below that may be helpful to the provider in order to successfully complete your FMLA documents: _____

_____

_____

_____

Please allow up to ten (10) business days for paperwork to be completed.

Patient Signature: _____