Date: ____/____/_____

Request for FMLA/Disability Form Completion

Phone: 402-436-2035 | E-mail: fmla.disability@nebraskaortho.com

Pre-Payment is Required. Please allow 5-7 business days for completion of form(s).

A fee per form is due prior to completion of the form(s).
The fee schedule is as follows:
$35 for initial form, $35 for updates for same qualifying condition.
You will be contacted by Sharecare with payment options after you return this paperwork.

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member-Name:_____

Patient Name:_____
(Last) (First) (Middle / Maiden)

Address:_____

City:_____ State:_____ Zip:_____

Social Security #: _____-_____-_____ Date of Birth: _____/ _____/ _____

Telephone #: _____/ _____/ _____

Email Address(*Required):_____

Physician:_____ **Body Part:**_____

Date Injury/Problem Began:_____ **Last Day Worked:**_____

For Patients requesting leave for themselves, what is the date(s) that you anticipate returning to work:_____

Please check a reason ☐ Continuous Leave ☐ Surgery and Post-Op Treatment ☐ Intermittent Leave

For Family Members requesting leave, what date(s) do you anticipate being out of work:_____

I authorize Nebraska Orthopaedic Center, PC to release the completed form(s) and/or the use and disclosure of my individually identifiable health information to:

Name/Organization:_____

Address:_____

City:_____ State:_____ Zip:_____

Telephone #: _____/ _____/ _____ Fax #: _____/ _____/ _____

Email Address: _____

Please check your preferred method of release:

☐ Email the form to the above email address
☐ Mail the form to the patient's address
☐ Mail the form to the Name/Organization above
☐ Fax the form to number provided above

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ **If I do not specify expiration this authorization will expire in 90 days.** If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by Federal Privacy Regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____(Please Initial)

Signature:_____ Date:_____

(Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other:_____)

Revised: 8/2021