Women's Health Center of Clarksville

2292 Dalton Drive Suite C
Clarksville, TN 37043
931-645-5595

Patient Request for Form Completion

_______ Disability Form
_______ Family Medical Leave Act (FMLA) Form
_______ Dr. Lisa McIntosh
_______ Dr. William McIntosh

Patient Name: ____
Patient Date of Birth: ________/________/________ Patient SSN: ________-________-________
Patient Phone Number: ________-________-________

After form has been completed:
_______ Mail form to:
Name: ____
Address: ______________________________ City/State/Zip: ______________________________
_______ Fax form to: ________-________-________
_______ Patient will pick up (**please keep in mind we have 10 business days**) Need form by: ________/________/________

For Disability Form

_______ Full Disability _______ Partial Disability
Injury Date: ________/________/________
Cause of Disability: ________ Illness (e.g. Surgery) ________ Work Related ________ Pregnancy
Last Day Worked: ________/________/________
Dates of Disability: Begins ________/________/________ Ends: ________/________/________
Additional Comments: ____

For Family Medical Leave Act (FMLA) Form

Dates of leave requested: Begins ________/________/________ Ends ________/________/________
Are you the patient? _______ YES _______ NO
If you are not the patient, state the relationship to the patient: ______________________________
Name: ______________________________ *If you are the Power of Attorney, please attach copy of POA.

Authorization to Release Protected Health Information

*I authorize the Women's Health Center of Clarksville to release any information concerning my health for the purpose of processing the requested form(s). This authorization shall be valid for the duration of my disability. A copy is available upon request.

Patient Signature: ______________________________ Date: ______________
Parent/Guardian Signature if patient is a minor: ______________________________ Date: ______________

FOR OFFICE USE ONLY: Number of forms completed: ________ Form Name/Type: ______________________________
Forms were: ________ Mailed ________ Faxed ________ Picked up
Employee Signature: ______________________________ Date: ______________

Form Completion Fee: $____________ Paid by : ________ Credit Card ________ Cash ________ Check
Employee Signature: Date: