Gilbert Center
For Family Medicine
652 East Warner Road, Suite 107, Gilbert, Arizona 85296
Phone (480) 539-8680 Fax (480) 539-1763

Effective January 1, 2022

For Patients Applying for Disability/ADA/ FMLA Coverage / Leave Forms:

For the office to complete **any forms** regarding your leave of absence, ADA Accommodations, FMLA or Disability, you must have received treatment in our office **within the last three months** and have discussed the reason for the leave with a provider in detail during an office visit.

In order for Disability, ADA Accommodations, or FMLA (leave) forms to be processed & subsequently completed by our office, the following must be submitted to office via fax, postal mail, email, or in person:

1) Disability, ADA Accommodations, or FMLA (leave) forms that need to be completed.

2) A signed Records Release to release medical information to the third party related to your Disability, ADA, or FMLA (patient must name third party on the release).

3) A Gilbert Center for Family Medicine Disability/ADA/FMLA worksheet

4) A non-refundable $100.00 administrative fee will be charged, **per set of forms**. The $100 fee is charged for all **initial** Disability/ADA/ FMLA form requests. This fee must be collected prior to Disability, ADA &/or FMLA forms being completed by the office. Renewal of existing intermittent FMLA/ADA forms without any changes, will be charged a $50 processing fee. Processing time for forms received by the office is 5-7 business days excluding Saturdays and holidays, after the office has received the above-mentioned items.

Expedited forms are charged a $200.00 non-refundable fee for **each initial set** of forms completed. Forms will be processed within 24-48 hours, excluding Saturdays and holidays.

Forms that are needing to be revised will be charged a $50 non-refundable fee per set of forms.

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Jeffrey Mikesell, PA-C Neerja Sethi, FNP-BC Kara Lindsay, FNP-BC

Tessa Fotoohi, PA-C

FMLA / DISABILITY/ ADA WORKSHEET

(**PLEASE NOTE**: There is a $100 processing fee per set of forms, with a turnaround time of approximately 5-7 business days (excluding Saturday), **AFTER** all necessary documents have been received, payment is made and appointment has been kept. Thank you!)

Patient's Name: _____ Date of Birth: _____

Please answer ALL questions to the best of your ability, ANY missing responses will delay the processing of your paperwork.

1. **What is your medical condition?** (i.e. back pain, pregnancy, migraines, depression /anxiety, family member illness, etc.) _____
2. **What is the approximate date the condition commenced?** _____
3. **What are / were your current symptoms? Please list.** _____
4. **Are you currently working? Yes or No?** _____
   a) is your leave intermittent/periodic days OR continuous/consecutive days? (SELECT ONE) _____
   b) if leave is intermittent - Please estimate frequency & duration of absences
   Frequency / Duration: ____episode/s every ____ week/s OR ____ month/s with each episode lasting: ____ hour/s OR ____ day/s per episode
5. **What was the first date you missed work?** _____
6. **What is the expected/anticipated return to work date?** _____
7. **Have you been referred to a specialist re: your condition? Yes or No?** _____
   a) if Yes, please list type of specialist/s & their name/s _____ _____
   b) if Yes, please list recommended treatment schedule (i.e. 1 visit, 1 time per week, for 4 weeks) _____
8. **Have you been hospitalized re: this condition? Yes or No?** _____
   a) if Yes, please list where & when. _____
9. **Have you had surgery related to your medical condition?** _____
10. **Is this medical condition work related?** _____
11. **LIST the job duties you cannot perform due to your condition.** _____
    DO NOT WRITE "ALL or NONE", please LIST duties you normally do when you're well. (i.e. interacting with customers, sitting, standing, lifting, walking, talking on phone, working at a computer, driving, etc.) _____ _____ _____ _____
12. **Once your forms have been completed & sent to requested persons, do you want your hard copy originals MAILED OR left at front desk for PICK UP?** _____

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Records Release
Disability/FMLA

_____ _____/_____/_____
Patient Name **Birth Date**

_____ _____-_____-_____
Address **Social Security Number**

Authorization

- ☐ I authorize the release of my medical records **from another provider/facility to Gilbert Center for Family Medicine.** (Provider/Facility → GCFM)
- ☐ I authorize the release of my medical records **from Gilbert Center for Family Medicine to another provider/facility.** (GCFM → Provider/Facility)

Records To Be Released **Medical records shall include all confidential aids, communicable disease, HIV related information, confidential alcohol or drug abuse related information, and confidential mental health diagnosis/treatment information. Release the following described medical records only (specify types and dates).**

- ☐ All medical records authorized to be released.
- ☐ Other medical records authorized to be released: _____

Provider/Facility Information

_____ (_____) _____-_____
Provider/Facility Name **Phone**

_____ (_____) _____-_____
Address **Fax**

Consent: **This consent will expire sixty (60) days after the signed date below.** I may revoke this authorization at any time providing I notify Gilbert Center For Family Medicine in writing to that effect. I understand that any release which was made prior to my revocation is in compliance with this authorization and shall not constitute a breach of my rights to confidentiality. I understand that a photocopy of this authorization is considered acceptable in lieu of the original. **I herby release Gilbert Center For Family Medicine from all legal responsibility or liability that may arise from the act I have authorized above.**

_____ _____/_____/_____
Patient Name **(If Minor: Parent / Legal Guardian)** **Date**

_____ _____/_____/_____
Patient Signature **(If Minor: Parent / Legal Guardian)** **Date**