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, 2024

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

For the office to complete leave, ADA/Work Accommodations, FMLA or Disability forms, 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. Providers will determine if the request is medically necessary and hold the right to refuse the completion of forms.

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

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

2) A signed & completed records release to the third party related to your Disability, ADA/Work, or FMLA. Signed release must include the third-party information completed by the patient.

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

4) A non-refundable $150.00 administrative fee will be charged, **per set of forms**. The $150 fee is charged for all **initial** Disability, ADA/Work Accommodations, & FMLA form requests. This fee must be collected prior to forms being completed by the office. **Existing intermittent FMLA** forms requiring renewal will be charged a $100 processing fee. Processing time for forms received by the office is 5-7 business days excluding weekends/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 weekends/holidays.

Forms requiring revision (changes) will be charged a $100 non-refundable fee per set of forms.

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Jaclyn Brown, MD Neerja Sethi, FNP-BC Kara Lindsay, FNP-BC

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FMLA/ADA/DISABILITY/Request for Accommodations WORKSHEET

(**PLEASE NOTE**: There is a $150 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 received, appointment kept, and provider has approved. 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**