NEUROLOGY CENTER OF FAIRFAX, LTD.

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FMLA Form

Patient Name: _____ Patient D.O.B.: _____ Date : _____

What is the condition for which you are seeking FMLA leave? _____

What date did the condition or disability begin? _____

Have you been hospitalized for this condition? Yes ◯ No ◯

If 'Yes', which hospital and date did this occur? _____

What is your current job title, description, and necessary duties?

_____

_____

What functions of your job are you unable to complete due to your condition or disability?

_____

_____

Which symptoms of your condition are preventing or restricting your ability to perform the duties of your job? What accommodations are you requesting? Please be specific.

_____

_____

_____

_____

Will you be incapacitated for a continuous period of time? _____

Is this a continuous leave based on the above medical condition? _____

What are the beginning and end dates for the period of incapacity?

Begin Date: _____ End Date: _____

When do you expect to return to work? _____

Is this request for intermittent FMLA leave? Yes ◯ No ◯

Will this condition cause episodic flare-ups (such as migraine, epilepsy, or multiple sclerosis), estimate the frequency and duration of the flare-ups that impair your ability to work:

_____

Please provide an estimate of how long a flare-up of your condition will prevent you from working:

_____

_____

Patient Signature: _____ Date: _____