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## Work Release Information

**(ALL spaces must be filled in for forms to be accepted and processed.)  
PLEASE ALLOW 7 BUSINESS DAYS FOR PAPERWORK TO BE COMPLETED.**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Reason for time off:

\_\_\_\_\_  
\_\_\_\_\_

Beginning Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

Is this leave with or without pay? \_\_\_\_\_

Which provider do you see? \_\_\_\_\_

**\*In order to receive your FMLA papers, the following must be filled out completely in addition to the above requested information:**

Intermittent leave: \_\_\_\_\_ Continuous leave: \_\_\_\_\_

\*Intermittent leave = continuing to work but can leave when necessary.

\*Continuous leave = not returning to work until ending date of leave.

**Please note that you will be responsible for picking up your completed forms.  
We DO NOT fax or mail the forms for you.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Clinic Initials: \_\_\_\_\_