OAM Orthopaedic Associates of Muskegon
West Michigan Spine Center
Grand Haven Bone & Joint
www.oamkg.com
www.wmspinecenter.com
www.ghboneandjoint.com
☐ 1400 Mercy Dr., Suite 100, Muskegon MI 49444 **231-733-1326**
☐ 1445 Sheldon Rd., Suite G1, Grand Haven MI 49417 **616-296-9100**

Disability/FMLA Form Request

Attach this form to the document to be completed for disability determination.

PAYMENT MUST ACCOMPANY THIS FORM in order for your form to be completed: First form = $25 (and $15 for each additional form)

Credit Card #:_____ Expiration Date:_____

We are glad to assist you in the completion of your Disability and FMLA form. There will be a 5 business day processing time frame, and a processing fee based on the type of form.

We understand you may an urgent deadline for your paperwork and will do our best to accommodate your needs; however all paperwork will be processed in the order that we have received it, without exception.

By law, we are required to have you provide us with a signed authorization (below) to disclose your information.

Today's Date: _____

Patient Name : _____ DOB:_____ SS#:_____

Daytime Phone Number: _____ OK to leave a detailed phone message? ☐ Yes ☐ No

Email: _____ Patient Mailing Address: _____

Date of Injury:_____ First Day Unable to Work:_____ Length of expected leave:_____

Fax or mail completed forms to: _____

_____

_____

I authorize Orthopaedic Associates of Muskegon to provide charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results, prognosis and treatment of any physical or mental condition, including: any disorder of the immune system, including HIV, AIDS or other related syndromes or complexes; any communicable disease or disorder; any psychiatric or psychological condition, including test results; any condition, treatment, or therapy related to substance abuse, including alcohol and drugs; and any non-medical information requested about me, including things such as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions. I also authorize Orthopaedic Associates of Muskegon to utilize my email address or cell phone number listed above as a point of contact for me.

I also acknowledge I am responsible to pay for the form completion prior to form completion or the faxing of completed forms.

Patient Signature: _____ Date:_____

*** You will be notified when your form is completed, if no forwarding instructions are given at the time of drop off.**