Dear Patient,

As part of your upcoming surgery planning, we want to make sure your Family and Medical Leave Act (FMLA) paperwork is completed accurately and on time. To do this, we have created a supplemental form that helps us gather the information we need from you.

Why this form matters

Your FMLA paperwork requires details that only you can provide, such as your job responsibilities, the length of time you are requesting off, and any follow-up dates that may impact your return to work. By filling out this form, we can complete your FMLA efficiently and without unnecessary delays or repeated phone calls.

When to return this form

- Please do not send us your employer's FMLA paperwork until you have been scheduled for surgery and have your date.
- Once you confirm your surgery date with our scheduler, submit this completed form together with your FMLA paperwork.
- Paperwork submitted without this form or before a surgery date is provided will not be processed.

What to expect

- Once you have a confirmed surgery date, bring/send this form with your employer's FMLA paperwork.
- Our providers will then complete your FMLA paperwork and return it to you or your employer as requested.

Thank you for your cooperation in helping us make this process smooth for both you and our care team. If you have any questions about the form, please contact our office.

Sincerely,
HonorHealth Orthopedics – Chandler Boulevard Team
480-963-2233

FMLA Info Sheet

Name: ____ DOB: _____________

Date of surgery/first day out of work: ____

Scheduled procedure: ____

Requested length of time off (12 weeks is standard): ____________________________

Date you were first seen for issue: ____

Dates of treatment for issue: ____

Scheduled follow-up/post-op dates: ____

Are you planning on returning to light duty work (work w/ restrictions)? Y N

Please provide us with a brief job description; what specifically will you not be able to do?

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When forms are complete:

- ☐ I will pick up the forms or have an authorized representative pick up on my behalf.
- ☐ Send forms to fax: ____

Patient Signature: ______________________________________ Date: _____________

------------------------------------- **Below is for office use only** ----------------------------------

Received on: ________________________ Due by: __________________________

CPT(s): _____________________________ ICD-10(s): ________________________