BLUEGRASS INTERNAL MEDICINE
QUESTIONAIRE FOR
FMLA, DISABILITY AND ATTENDING PHYSICIAN FORMS

There is a $25 charge for all forms to be filled out. You are required to pay at Check-Out before these forms are filled out. Thank you for patience.
Due to HIPAA, you are required to sign an authorization to release information before the form can be filled out.

YOUR NAME: ____

CELL NUMBER: ______________________________________ **HOME NUMBER:** ____________________

PATIENT NAME: _____________________________________ **DATE OF BIRTH:** ____________________

Part I - FMLA (if this does not apply to you – go to Part II).

WHAT IS THE DIAGNOSIS THAT YOU ARE USING FOR FMLA: _______________________________
Examples: Migraines Diabetes COPD Heart Disease

FIRST DATE OF FMLA, OR FIRST DAY OFF WORK: ____

Place of Employment: ____

Is this paper a Family Medical Leave for work because of: (Select One)

☐ A sickness for you or ☐ Sickness for a family member(Please Specify): ______________
Example: Mother, Father, Wife, Child

Is this for: (Select one) ☐ **Intermittent Leave** or ☐ **Continuous Leave**

If Continuous Leave, what is the date of the first day you were off: __________________________

When do you plan to return to work: ____

Do we need to FAX this to your work? ☐ Yes or ☐ No **Fax #**____________________

If we fax this, do you want the original mailed to you? ☐ Yes or ☐ No
(Otherwise a copy will be placed in your electronic health record and the original form destroyed.)

PART II - Disability/ATTENDING PHYSICIAN STATEMENT:
What diagnosis are we filling this out for? ____

Have you been in the hospital ? ☐ Yes or ☐ No

Date Admitted to Hospital ______________________**Date Discharged from Hospital** __________________

Are you considered permanently disabled by Social Security? ☐ Yes or ☐ No

First Date off work _____________________________ **When you are returning to work**___________________

Have you seen another physician, example – a specialist, if so, who did you see: ___________________________
Do we need to FAX this to your insurance? ☐ Yes or ☐ No **Fax #**______________________
If we fax this, do you want the original mailed to you? ☐ Yes or ☐ No
(Otherwise a copy will be placed in your electronic health record and the original form destroyed.)