ORTHOPEDIC CENTERS OF COLORADO

FMLA / FAMLI / Disability Form Fees

Date: _____ Provider's Name: _____

Patient Name: _____ Date of Birth: _____

Patient/Guardian Contact Phone Number: _____

Beginning January 19, 2024, there will be a $35 charge associated with completing and submitting all FMLA, FAMLI and Disability claim forms for patients. Fees are charged per form, to be paid upon request for completion.

Forms will be completed within 7 days of receiving all required documentation below.

- Is your request for leave due to an injury or a surgery? _____
- If due to an injury, please state the nature of the injury: _____
- If due to surgery, what is your planned surgery date? _____
- What surgery will be performed? _____
- What is your job or essential job functions? _____
- Are there any specific restrictions that need to be in place for your job? _____

  _____
- What dates are you requesting to be off work? _____ through _____
- If the above date is prior to the day of surgery, please be specific as to why? (Disability/FMLA coverage typically will not cover your absence prior to surgery) _____
- When do you plan to return to work? (Be specific with dates, with/without restrictions) _____

  _____
- Who do these forms need to be submitted to?

  Name: _____

  Title: _____

  Phone: _____ Fax: _____ Email: _____

By signing below, I acknowledge I am requesting Orthopedic Centers of Colorado to complete and submit my FMLA / FAMLI / and or Disability claim forms to the designee listed below. I also agree with all fees associated with completing forms.

_____	_____	_____
Patient/Guardian Name (Printed)	Patient/Guardian Signature	Date