FMLA QUESTIONNAIRE
Please fill out completely
Fee $25

Name_____Date_____

Payment _____cash _____check _____ charge card

ALL QUESTIONS MUST BE ANSWERED TO COMPLETE YOUR FORMS IN A TIMELY MANNER

Last day of work?

What is the reason for your disability or time off work?

Is this problem work related? (yes or no)

What specific date did the doctor state you could return to work?

Why can't you work or what are your limitations?

Are you or have you had surgery or a hospitalization for this problem?

When was/is your surgery or hospitalization for this problem?