The Women's Clinic of Northern Colorado

DISABILITY CLAIM FORM

1. **Name** (First) (Initial) (Last)	2. **DOB:**
3. **Address** (Street) (City) (State)	4. **Telephone #:**
5. **Name and Address Where Completed Forms Are To Be Sent**: (*Please make sure you have signed your medical release on your form)*	
6. **Nature of Disability**: _____Pregnancy _____Surgery _____Illness	
7. **Dates of Total Disability**: From: _____ To: _____	
8. **If for pregnancy and you are requesting time prior to delivery, what is the reason?**	
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO COMPLETE THIS FORM. _____ **Patient Signature**	