The Women's Clinic
of Northern Colorado

DISABILITY CLAIM FORM

1. **Patient Name** (First) (Initial) (Last)	2. **Patient DOB:**
3. **Address** (Street) (City) (State)	4. **Telephone #:**

5. **How would you like to receive your completed forms?**

EMAIL: **FAX:**

6. **Reason for requesting Disability**:

_____Pregnancy _____Surgery _____ Other

7. **Dates of Total Disability for Continuous Leave**:

From: _____ To: _____

8. If you are requesting Reduced Hours or Intermittent Leave - Please specify dates as needed below :

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO COMPLETE THIS FORM.

_____
Patient Signature

☐ check mark this box if paperwork is for spouse/partner of WCNC patient

***PLEASE ALLOW 7-10 BUSINESS DAYS FOR DISABILITY FORMS TO BE COMPLETED & SIGNED**

***ALL APPLICABLE SECTIONS MUST BE FILLED OUT TO COMPLETE FORMS**

PT STICKER HERE