Dr. Phillips Medical Wellness Center
2915 Lakeview Drive Suite #1001
Casselberry FL, 32730
Phone #: [407] 900-0613
Fax #: [407] 335-6945
Email: office@drphillipsmwc.com

Family and Medical Leave Act (FMLA) & Disability Request Screening Form

This screening form is required for all patients requesting completion of **FMLA or Disability Forms**. The purpose is to determine whether our office is able to provide the necessary medical certification for your request, including temporary/continuous leave. **Please note that not all conditions or situations qualify under FMLA and Disability guidelines**. This form allows us to evaluate your situation and/or medical condition and individual circumstances to determine whether your request meets the clinical criteria to support your application. Completion of this form does **not guarantee approval**.

All patients must:

1. Complete this screening form in full prior to the initial consultation.
2. Schedule the initial consultation with your primary care provider to review this form and bring a blank copy of the requested form (**FMLA or Disability Form)** with any additional supporting documentation.
    a. You can expect approval or denial based on the criteria and medical decision.
    b. Provide the deadline for the form to be completed.
3. Upon approval by the medical provider, schedule a second appointment to get the FMLA or Disability Form completed.
    a. Please be aware that forms are not being completed, amended or updated outside of a medical visit.

I. Requested Form Type; Provide details on Section V.:

☐ Disability
☐ FMLA:
☐ Employee's serious health conditions:
    ☐ Chronic conditions
    ☐ Permanent or Long-term conditions
☐ Family member's serious health condition
☐ Military caregiver leave of current service member
☐ Pregnancy

II. Type of Leave Requested:

☐ *Continuous Leave*: A single block of time for a condition such as surgery, hospitalization, or continuous treatment.

☐ *Intermittent Leave:* Leave taken in separate blocks of time due to a single qualifying reason, such as periodic flare-ups, treatments, or appointments) – We MUST have supporting clinical documentation and frequency of visits and specialists notes for this type of serious condition and notes from specialist.

☐ *Reduced Schedule Leave* (A temporary modification of work schedule, such as fewer hours per day or fewer days per week)

Dr. Phillips Medical Wellness Center
2915 Lakeview Drive Suite #1001
Casselberry FL, 32730
Phone #: [407] 900-0613
Fax #: [407] 335-6945
Email: office@drphillipsmwc.com

III. Patient Information:

Name: _____
Date of Birth: _____
Phone Number: _____
Address: _____
_____

IV. Medical Provider Information:

- Primary Care Provider at DPMWC: _____
- Specialist: _____
  - Department/Specialty: _____
- Specialist: _____
  - Department/Specialty: _____

V. Reason for Leave (check all that apply):

☐ Patient's own serious health condition (unable to perform essential job functions)
Details _____
_____

☐ To care for a spouse, child, or parent with a serious health condition
Details _____
_____

☐ Pregnancy, prenatal care, or recovery from childbirth
Details _____
_____

VI. Please specify reason for continuous leave

☐ Hospitalization/ rehab
☐ Surgery

Dr. Phillips Medical Wellness Center
2915 Lakeview Drive Suite #1001
Casselberry FL, 32730
Phone #: [407] 900-0613
Fax #: [407] 335-6945
Email: office@drphillipsmwc.com

☐ Continuous Care/Daily Appointments
*If checked, please specify the frequency and type of appointments: _____
Supporting Documentation Requirement: Certified letter from specialist indicating need for continuous leave.

VII. Details of Leave:
Reason: _____
Start Date: _____
Expected End Date: _____
Specialty Provider Overseeing Treatment: _____

Patient Acknowledgment:

I, _____, understand that continuous FMLA/ Disability Leave is granted only for hospitalizations, surgeries, or continuous care that requires continuous multiple and frequent appointments with the specialty provider performing the treatment. I agree to provide any necessary documentation and updates regarding my appointments and medical status.

I understand that submitting this form does not guarantee approval or certification of FMLA/Disability Leave. This form is used to determine whether my condition qualifies for FMLA/Disability certification through Dr. Phillips Medical Wellness Center as my primary care physician.

I acknowledge that continuous leave requires clear medical justification and supporting clinical documentation. Intermittent or reduced schedule leave requires ongoing medical documentation and may require documented additional visits with my primary care provider to evaluate the progression and/or specialist. The frequency and duration of such leave will be determined based on medical necessity and standard treatment guidelines. If no prior documentation of serious health condition may not be approved and if follow up with specialist not compliant may disqualify for serious health condition.

I further understand that:
Our office will review your request in accordance with federal FMLA/Disability guidelines and medical standards.
Certification of FMLA/Disability leave will only be provided if your condition meets the applicable criteria.
If adequate medical documentation is not provided, or if your condition does not meet the requirements, our office may be unable to complete or support your FMLA/Disability leave request.

By signing below, I confirm that I have read and understand this acknowledgment.

Signature: _____ Date: _____

Non-Discrimination Statement:
Dr. Phillips Medical Wellness Center does not discriminate based on race, color, national origin, sex, age, disability, or

Dr. Phillips Medical Wellness Center
2915 Lakeview Drive Suite #1001
Casselberry FL, 32730
Phone #: [407] 900-0613
Fax #: [407] 335-6945
Email: office@drphillipsmwc.com

any other characteristic protected under applicable federal and state laws. All patients are entitled to fair and equal care and consideration in accordance with these guidelines.