

FORM/LETTER COMPLETION REQUEST

TO PREVENT DELAY IN COMPLETION, PLEASE COMPLETE THIS FROM IN ITS ENTIRETY

Patient Name: _____ DOB: _____

<p>PHYSICIAN (PLEASE SELECT)</p> <p><input type="checkbox"/> EDWARD J. BIEBER</p> <p><input type="checkbox"/> CHRISTOPHER J. CANNOVA</p> <p><input type="checkbox"/> MAHIDHAR M. DURBHAKULA</p> <p><input type="checkbox"/> SRIDHAR M. DURBHAKULA</p> <p><input type="checkbox"/> IRA D. FISCH</p> <p><input type="checkbox"/> ANDRE R. GAZDAG</p> <p><input type="checkbox"/> CRAIG A. MILLER</p> <p><input type="checkbox"/> KURT C. SCHLUNTZ</p> <p><input type="checkbox"/> JOSEPH R. O'BRIEN</p> <p><input type="checkbox"/> ERIC J. FEUCHTBAUM</p> <p><input type="checkbox"/> ANDREW S. HOLMES</p> <p><input type="checkbox"/> TIMOTHY BHATTACHARYYA</p> <p><input type="checkbox"/> ROBERT R. BUBER</p>	<p style="text-align: center;">TYPE OF REQUEST (Please Select & Complete)</p> <p><input type="checkbox"/> Continuous Leave</p> <p style="margin-left: 20px;"><input type="radio"/> First Date of Leave: _____</p> <p style="margin-left: 20px;"><input type="radio"/> Last Date of Leave: _____</p> <p style="margin-left: 20px;"><input type="radio"/> Estimated Return to Work Date: _____</p> <p><input type="checkbox"/> Intermittent Leave</p> <p style="margin-left: 20px;"><input type="radio"/> Effective From _____ through _____</p> <p style="margin-left: 20px;"><input type="radio"/> _____ Hour (s) per day; _____ days per (circle one) week or month</p> <p><input type="checkbox"/> Light Duty</p> <p style="margin-left: 20px;"><input type="radio"/> Effective From: _____ through _____</p> <p style="margin-left: 20px;"><input type="radio"/> Part time: work _____ hours per day _____ days a week</p> <p style="margin-left: 20px;"><input type="radio"/> Other Light Duty: _____</p> <p><input type="checkbox"/> Other Type of Request(s)</p>
<p>RETURN COMPLETED FORMS</p> <p><input type="checkbox"/> Fax: _____</p> <p><input type="checkbox"/> Email: _____</p> <p><input type="checkbox"/> Mail to patient's address on file</p> <p><input type="checkbox"/> Will pick up</p>	

Form Service Fee

1-4 pages = \$20 | 5 pages or more = \$40

We require 7 business days for completion of all forms/letters

Service fees apply to each request and will be collected at the time of pickup

By signing my name below, I certify that I have read the above information. My signature also certifies my understanding of, and agreement with the above policies. I understand I am responsible for the service charges not paid by my insurance.

Please note that requests are granted based on your current orthopedic diagnosis only!

Patient (or Guardian) Signature

Date

***** REQUESTS WITHOUT A SIGNATURE & DATE WILL NOT BE PROCESSED. *****

J. Patrick Caulfield, M.D. • Edward J. Bieber, M.D. • Ira D. Fisch, M.D. • Kurt C. Schluntz, M.D. • Andre R. Gazdag, M.D. • Christopher J. Cannova, M.D. • Mahidhar M. Durbhakula, M.D. • Sridhar M. Durbhakula, M.D. • Craig A. Miller, M.D. • Joseph R. O'Brien, M.D. • Eric J. Feuchtbaum, M.D. • Andrew S. Holmes, M.D. • Timothy Bhattacharyya, M.D. • Robert R. Buber, M.D.