

MIDLANDS ORTHOPAEDICS, PA
1910 Blanding Street, Columbia, SC 29201
(803-256-4107)

Complete the following information to request a Certification of Health Care Provider statement for the Family and Medical Leave Act (FMLA).

Employee's Name: _____

Patient's name (if different from employee): _____

Patient's Date of Birth: _____

Address: _____

City: _____ State: _____ ZIP: _____

Leave of Absence:

I am requesting a leave of Absence beginning _____ through _____.

Procedure Information:

Procedure performed was ___ Inpatient surgery ___ Outpatient surgery ___ MRI ___ Injection

Date of Procedure: _____

Give a brief description of surgery or procedure performed (example: hip, knee, back):

Treating Physician: _____

Is patient attending Physical Therapy? _____

List the name, address, and/or fax number where your forms should be sent:

Name: _____

Address: _____

City/State/Zip: _____ Fax #: _____

I understand that up to 10 business days may be required for my form(s) to be completed. I will direct all questions regarding forms to 803-933-6132.

Signature: _____ Date: _____
