Disability Forms

*****ATTENTION*****

PLEASE ALLOW 3 BUSINESS DAYS FOR PAPERWORK TO BE COMPLETED.
IF YOU DO NOT COMPLETE THIS FORM IT WILL DELAY IN THE COMPLETION OF YOUR FORMS.

Which doctor is writing you out of work? Gatto Longworth Lowenstein Naseef

Patient's Name:

____
(Please Print)

Date you are dropping this form off: _____/_____/_____

Where would you like the form to be sent when completed? (Please check one)

☐ Patient will Pick-Up

☐ Mailed to Patient

Number where you could be reached if there is a question: (   ) _______-________________

First day of disability: _____/_____/_____

Date you plan to return to work.
If unknown, you **MUST** put an estimated date: _____/_____/_____

If you are extending disability, please write the reason:

____

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____

Additional
Information:

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