

## Disability/Other Document Drop-Off

Which physician?      Gatto                      Lowenstein                      Naseef

Patient's Full Name: \_\_\_\_\_  
(Please Print)

Date you are dropping off form: \_\_\_\_\_

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

☐ Fax to \_\_\_\_\_

☐ Patient will Pick-Up

☐ Mailed to Patient

Number where you could be reached if there is a question: \_\_\_\_\_

First day of Disability/FMLA: \_\_\_\_\_

If you are extending disability, please write the reason:

---

---

---

---

Additional Information:

---

---

---

---

---

---

### ATTENTION

Please allow **5 business days** for paperwork to be completed. If you **do not** complete this form, it will delay in the completion of your forms.