MOFFITT CANCER CENTER

Disability Office
FMLA / ADA WORKSHEET
Please complete this in full so that we may begin to process your form.

Today's date: ___/___/____ **Patient Name:** _____

Patient's DOB: _____ **Patient's MR#** (if known): _____

Name of person requesting leave (patient/family member/caretaker of patient):

_____

Please select one of the following so we know what schedule change is needed:
Will you continue to work while receiving treatment? □YES □NO
If yes, please list date reduced work schedule should begin: **____/___/___**
Estimated days needed off per month: _____
OR
Will you stop working completely while receiving treatment? □YES □NO
If yes, please list first date needed off work: ____/___/___
Date you plan to return to work (if known): ___/____/_____

Once form is completed where should we send it? (Please check ONLY ONE.)
□**Fax** to insurance company/employer ( ) _____-_____
Attn: _____
OR
□**Mail** to Patient or Disability Provider or Human Resources:
Mailing address: _____
_____
Attn: _____

Processing of paperwork will take up to 15 Business Days from date of receipt of this worksheet. Please contact your employer or disability provider for an update on the form. If it has been more than 15 business days since the form was submitted to the Disability Office and it has not been received by your employer or insurance provider, please leave a message on the Disability Line at (813) 745-2356 or email disabilityoffice@moffitt.org or via fax at (813) 745-2002 and someone will return your call by the end of the next business day. Once completed, forms will be accessible on the Moffitt Patient Portal.

Signature of person completing form: _____