SPACE COAST
FOOT & ANKLE CENTER
Specializing in Medicine & Surgery of the Foot & Ankle

# FMLA/Disability Paperwork Request

**This form must be completed for EACH request for Dr. MacKenney to complete FMLA or Disability paperwork.**
**Dr. MacKenney will not consider your paperwork until ALL QUESTIONS are answered. A $20.00 Fee is due at completion**

Patient Name:_____ Date of Birth:_____

1. Start Date:_____ **to** Planned End Date:_____
2. Type of leave you're requesting (**Choose One**):
   - ❑ Completely off work for one continuous period (usually for outpatient surgery)
   - ❑ Reduced Schedule/Part Time Status
     How many hours per day do you plan to work?_____
     How many days per week to you plan to work? (List specific days if applicable)
     _____
   - ❑ Intermittent Time-Off
     *(I need to miss part or a whole day periodically for flare-ups)*
     How often do you expect to require time off for flare ups?
     _____ times per ❑ week / ❑ month / ❑ year
     To last: _____ ❑ hours / ❑ days each time
   - ❑ Reduced Duties Only
     *(I plan to work, but need special accommodations or limited duties)*
3. Will your job allow you to wear a protective boot (i.e. cam walker) while working? ❑ Yes ❑ No
4. Will your job allow you to work with reduced duties or limitations? ❑ Yes ❑ No
   ***If yes**, describe your basic duties:* ❑ *See attached job description*

   _____
   _____
   _____
   _____
5. If you answered "yes" on question 5, can you complete all of these duties? ❑ Yes ❑ No
   *If no, list specific duties you CANNOT DO:*

   _____
   _____
   _____
   _____

*If you have questions or need assistance, please let us know.*

**This request must be submitted a *minimum* of *3 business days* before it is due.**

Hand-deliver or fax to 321-259-4369 along with your FMLA or Disability paperwork.