PREGNANCY DISABILITY

Date: _____

Patient's Name: _____ Date of Birth: _____

Employer: _____

Treating Doctor: _____

Date of last monthly cycle: _____ Due Date: _____

Expected delivery type: ☐ Vaginal ☐ C-section

Hospital to be delivered at: _____

First date off: _____ Return to work date: _____

Indicate below if you want form picked up, mailed or faxed, if so provide one of the following:

Fax #: _____

Mailing Address: _____

Contact #: _____

Paid: _____

NOTE: The doctors allow six weeks for a vaginal delivery and 8 weeks for a c-section unless other complications arise.