PREMIER WOMEN'S HEALTH OF MINNESOTA

FMLA/Short Term Disability Information

Date: _____

Patient Information

Patient name: _____

Date of birth: _____ Phone number: _____

Paperwork Instructions

Pick-up at OBGYN West: Yes ☐ No ☐

Pick-up location: _____

OBGYN West send via fax: Yes ☐ No ☐

Fax number: _____

Attention: _____

Company name: _____

OBGYN West send via email: Yes ☐ No ☐

Email address: _____

Please allow at least one week for your paperwork to be completed.

Revised: 11/20/25