DENT
NEUROLOGIC INSTITUTE

Payment Received ☐

***to be completed by patient for each form request****
Please allow 10 business days to complete this request.

# Forms Completion Request

**FORMS PRICES:**
DBL $20
PFL $25
DMV (pt request) $25
FMLA $40
Life Insurance $30
ADA $25
NYS EDU $15
All Other $10:
*(additional $10 beyond 2 pages)*

**SECTION I – PERSONAL DATA** Today's Date: _____

Patient Name: _____ DOB: _____

Which provider do you see at Dent? _____

If we have questions, what is the best number to reach you at? _____

Once this form is complete please advise on how you would like us to handle:
□ I will pick the form up; call me at: _____
□ Fax this form to _____ ATTN: _____
□ Mail this form to (name) _____ (address) _____
□ Upload this form to the patient portal

**SECTION II – RECORDS RELEASE**

I hereby authorize Dent Neurologic Institute to release my medical information as requested on the attached form and to distribute as indicated in Section I.

_____
**Patient Signature** **Date**

**SECTION III – DISABILITY**

Approximate date/ year symptoms began:
_____

Last date worked: _____

If working part-time, date begun: _____
(hours/days, or days/week)

Current work restrictions: _____
_____
_____

**SECTION V- Work Accommodation/ ADA**

Employer/Job Title: _____

Job Functions: _____

Reason for accommodation; what are you unable to do at work?
_____
_____
_____

What work accommodation do you need?
_____
_____
_____

**SECTION IV- FMLA/ PFL**

☐ **Self**
☐ **Family**

Start Date: _____

Requested FMLA/ PFL Leave Type:

☐ **Continuous Leave**
☐ **Intermittent Leave**

**Please note your "requests" here regarding your restrictions (hours/days, weeks/months, etc.)** ***Subject to providers review and approval if appropriate*** _____
_____

Revised 09.02.26 NT