

**Seattle OB/GYN Group**  
**Official FMLA/Pregnancy Disability Form**

Patient Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Estimated Date of Confinement: \_\_\_\_\_ Expected \_\_\_ Actual \_\_\_

Diagnosis: Pregnancy

Complications, if any: \_\_\_\_\_

Expected Recovery:

6 weeks if vaginal delivery

8 weeks if Cesarean delivery

Full return to usual duties after FMLA unless otherwise noted

Tax ID: 91-1665536

Hospital: Swedish Medical Center, 747 Broadway, Seattle, WA 98122

If patient requires an additional form, there will be a pre-paid fee of \$25.

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE ALLOW 5 BUSINESS DAYS FOR THE COMPLETION OF ANY PAPERWORK**